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ABSTRACT

This publication provides tools, local contacts, and ideas for program and policy initiatives in urban maternal and child health (MCH). Each CityMatCH member health department attending an August 2001 urban leadership conference submitted a profile of current MCH efforts. Section one, "Summing Up," examines lessons learned (e.g., local health departments are focusing energy on creative, effective ways to inform and educate the public about key MCH issues, and breathing new life into existing programs can lead to more convenient, direct services and increased access for consumers). Section two, "About Lessons Learned," explains how to use profiles, presents a listing of leading urban health department initiatives in MCH, offers a sample profile form, and includes two profile indexes (target populations and approaches and essential MCH program functions. Section three, which comprises the bulk of the document, presents CityMatCH profiles of leading urban health department initiatives in MCH. Each profile presents name, address, telephone, fax, and e-mail information; then lists essential MCH functions and MCH initiatives and offers information on: project description, objectives, barriers encountered, strategies to overcome barriers, funding source, role of the health department, accomplishments, and lessons learned. Two appendixes include CityMatCH membership listing and publications listing. (SM)

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Lessons Learned
2001

Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health

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CityMatCH

From the 2001 CityMatCH
Urban MCH Leadership Conference
Bringing Women's Health Center Stage
August 26-29, 2001

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Lessons Learned 2001:

Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health

From the City**M**at**CH**
Urban MCH Leadership Conference
Nashville, Tennessee
August 2001

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City**Mat**C**H** is a national organization of urban maternal and child health programs and leaders. City**Mat**C**H** was initiated in 1988 to address the need for increased communication and collaboration among urban maternal and child health programs for the purpose of improving the planning, delivery, and evaluation of maternal and child health services at the local level. City**Mat**C**H**, through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for addressing the health concerns of urban families and children. City**Mat**C**H** also has developed a centralized information base about the current status of maternal and child health programs and leaders in major urban health departments in the United States.

For more information about City**Mat**C**H**, contact Dr. Magda Peck, City**Mat**C**H** Executive Director/CEO, Department of Pediatrics, University of Nebraska Medical Center, 982170 Nebraska Medical Center, Omaha, NE 68198-2170, Phone: (402) 561-7500 or visit us at our website http://www.citymatch.org.

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Lessons Learned 2001: Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health is the fifth in this general publication series from City**MatCH**, the national organization committed to improving the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities. The intent of this compendium is to facilitate easy access to selected urban public health practices aimed at improving the health of women, children and families. Highlighted are innovative approaches and replicable practices which address contemporary public health problems facing children and families in America's cities.

Readers seek advice on moving from "project" to scale and on developing creative collaborations to overcome the barriers to program effectiveness. They need effective methods to obtain and sustain resources. *Lessons Learned 2001* provides ideas, tools, local contacts, and ideas for program and policy initiatives in urban maternal and child health (MCH). Many of the MCH initiatives described have not been formally evaluated, their value lies in the initial research, groundwork and concepts they offer for the development or enhancement of future local, urban health projects.

Each City**MatCH** member health department attending the August 2001 Urban MCH Leadership Conference submitted a profile of a current MCH effort as part of their active participation. These health departments deserve special recognition for passing on valuable lessons and for striving to better the lives of children and their families in urban communities. Kudos to Conference co-chairs: Gayle Bridges Harris (Durham, NC) and Llamara Padro Milano (Syracuse, NY), for steering a successful conference experience.

Producing *Lessons Learned* is a labor-intensive task, skillfully executed by co-editors Maureen Fitzgerald and Kelly McIntosh. Additional special thanks to Deanna Bartee, Michelle Coe, Diana Fisaga, Jeanette Leaper, Jeff Rabey, Janet Rogers, Joan Rostermundt Patrick Simpson and Jennifer Skala at City**MatCH** and Kevin Gamble at the University of Nebraska Medical Center's Printing Services for helping to construct this user-friendly tool. The Maternal and Child Health Bureau, HRSA, provides essential funding to allow City**MatCH** to continue to serve as a partner for information and communication; we thank them for their ongoing support.

We hope *Lessons Learned 2001* will spark action and change for local efforts to improve the health of women, children and families. Please let us know if and how this tool has proven most useful to you.

Sincerely yours,

Magda

Magda G. Peck, ScD
CEO/Executive Director, City**MatCH**

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SORTING IT OUT: WHAT LESSONS HAVE WE LEARNED?

The 12th annual Urban MCH Leadership Conference was held in Nashville, Tennessee in late August 2001. Among those in attendance were more than seventy designated maternal and child health leaders from City**Mat**CH member city/county public health departments. Each of these leaders, emissaries of health departments in major urban areas, whose jurisdictions include one or more cities with populations of over 100,000 or greater, submitted a "profile" outlining a current, local, urban MCH effort as a requisite for their federally subsidized attendance. Profiles submitted described a given activity, following a profile questionnaire which delineates budget, funding, expected outcomes, evaluation efforts, accomplishments, barriers to programmatic success, efforts to overcome challenges, key partners and overall lessons learned.

Every profile included in this compendium has been reviewed for content, edited, updated where possible, reviewed and indexed. From the submitted profiles, City**Mat**CH extracted data to create two profile indices. The first index describes each profile by the type of initiative and the second index delineates them by the Essential MCH Functions, as described by Grason and Guyer in ***"Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America."***

The mission of City**Mat**CH, the nationally recognized membership organization of city and county health departments' maternal and child health (MCH) programs and leaders representing urban communities in the United States, is to improve the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities. City**Mat**CH provides a peer-based support system for those striving to upgrade and enhance MCH practice and policy at the community, state and national level. In the years since the inception of City**Mat**CH, the organization has become a national resource center for data, policy and capacitybuilding on urban MCH. In 1996, City**Mat**CH recognized a unique opportunity to share local "best practices" and "models that work" and launched this series, *"Lessons Learned: Profiles of Urban Health Department Initiatives in Urban Maternal and Child Health."*

As has been the case since 1996, the final question of the profile asks participants some variant of ***"What is the greatest lesson your health department has learned and can share with others about this activity?"*** Each year, a number of themes repeat themselves in some variation and each year a few new thoughts emerge. Not all the answers are found in reading responses to the last question. A number of themes emerged from the descriptions of barriers health departments encountered when undertaking their projects, and from the strategies health departments used to overcome them. Still others came from the project descriptions and the project accomplishments. Here are the main themes that emerged from the review of *Lessons Learned 2001:*

1. LOCAL HEALTH DEPARTMENTS ARE FOCUSING ENERGY ON CREATIVE, EFFECTIVE WAYS TO INFORM AND EDUCATE THE PUBLIC ABOUT KEY MCH ISSUES.

"Community assessment of gaps in services often provides new opportunities for health education and prevention activities." Knoxville, TN

Many profiles in 2001 outlined unusual ways to create a more informed public. The 'Folic Acid Man' of Wilmington, DE, and Nashville's 'Tooth Fairy' all support the concept that learning should be a fun and easy activity. Wilmington also provided a formula for maximum impact: *"Simple messages are best: clear visuals with verbal interaction are key."* The City of Hartford (CT) Health Department, utilizing city vehicles, developed an educational awareness campaign with messages placed on the sides of Department of Public Works Sanitation Trucks. This clever collaborative effort of the city departments of Health, Public Works, and Housing and Community Development clearly met its stated objective to redefine how educational and awareness messages are provided to the public. Another clever mechanism for getting word out was offered by the Oklahoma City-County Health Department. After a series of focus groups were held, staff developed and implemented a plan to get health-related information printed onto dividers and placed into binders that were then given to high school suppliers. High school students assisted in both the development and the format of these materials, and the health department found that by printing health information on needed materials, they had increased the chances that it would be read and accessible.

Vanderburgh County (IN) realized that they needed to do more to promote their services through the course of their FIMR project. *"Through this initiative, we have also learned that we need to advertise our existence and services to the community in order that all residents have a source of obtaining health information if they don't receive it from*

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their physician." Lessons learned come to us in many different vehicles, and recognizing a need is the first baby step toward change.

Measuring success (and failure) is an important aspect of promotional campaigns. Not all submissions to *Lessons Learned* have been through formal or informal evaluations, although some describe fairly sophisticated evaluation procedures. San Diego, CA presented a media awareness campaign which generated over 1, 000 uninsured families seeking health insurance within just ten weeks! Some promotional messages were designed to create awareness of a particular health issue, others were designed to advertise and alert consumers to programs and services. Still other health departments reported receiving the benefits of increased news coverage regarding health issues of the day. Clearly, health departments realize that they must communicate effectively to the different populations they serve or organizations with whom they collaborate.

2. COMMUNITY PARTNERSHIPS BETWEEN HEALTH DEPARTMENTS, POLICYMAKERS, OTHER HEALTH CARE PROVIDERS, FAMILIES, AND INTERESTED OTHERS ENHANCE LOCAL PUBLIC HEALTH IMPACT ON MATERNAL AND CHILD HEALTH.

"Collaboration with community partners contributes to a more comprehensive program." Knoxville, TN

Mobilizing community partnerships is an essential MCH function, carrying with it a host of unique issues and concerns. The development of collaborations can lead to positive outcomes for MCH, but requires significant effort. To carry out many projects successfully, local Health Departments need to elicit strong commitment from unrelated entities. Tacoma-Pierce (WA) County Health Department's acknowledged that, as with any effort that requires disparate people to cooperate, *"Collaborations between public and private agencies take a lot of education and trust building before they can be successfully implemented."* Their Newborn Referral project was born out of a coalition of concerned businessmen, educators and human service providers, seeking to prevent abuse and neglect of children and promote health outcomes in families through the provision of family support services.

Finding the right partners to provide the right services is paramount, yet sometimes determining who should be at the table is simple. The Long Beach Department of Health and Human Services developed their own collaboration between seven agencies, each of which considered improving the quality of life for children a priority. *"Collaborative partners were easy to identify and included the local community college, the City's Library Department, a local community clinic with a long history of providing outreach and education and collaboration, the local school district Head Start program, a community-based agency specializing in outreach to Southeast Asian populations, and a local child care agency."*

In other instances, the choice of partners is not so intuitive. Health Departments consistently demonstrate creativity and take innovative approaches to assembling coalitions. They most often, however, look to the community for input. *"The community knows what will and will not work for them. Agencies can provide a better service if the community is involved in the planning, decision-making and implementation. This kind of partnering takes time, but the outcome is more rewarding for both."* (Modesto, CA) Health Services Agency, for their Teen Life Challenge, a community project to reduce teen pregnancy. Improving health outcomes for women, children, families and youth is the overarching goal.

3. ROLES PERFORMED BY THE LOCAL PUBLIC HEALTH DEPARTMENT ARE CRUCIAL, BUT THEY AREN'T ALWAYS THE SAME AND THEY SOMETIMES DEFY EASY DESCRIPTION.

"Portland Public Health Division has planned and implemented this program in partnership with the school system and the hospital and has the responsibility for the on-going evaluation and management." Portland, ME

One question included in the profile questionnaire asks what role(s) the health department played in the project submitted. Answers were often complex, and ran the gamut from idea generation to research and data gathering, to convener of collaborations, to direct services to evaluation and back again. Health departments identify and assess problems, creating the spark that draws together community groups and other partners with disparate ideologies, agendas and funding streams, to create change. Spokane (WA) Regional Health District described the health department's role in their WIC Check Express program as, *"catalyst, convener and facilitator in working with our community partners."* Without question, the essential MCH function *of "providing leadership for priority setting,*

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planning and policy development to support community efforts to assure the health of women, children, youth and their families," is clearly at play in health department roles outlined in Lessons Learned 2001. Other profiles describe a more traditional public health model of start-to-finish involvement and direct service provision. The Philadelphia Department of Public Health's Osteoporosis Screening Program was fully under their auspices, as they *"assumed full responsibility for planning, and implementing this initiative, including training health center staff and providing education materials.* All projects included elements of either catalyst or autonomous project direction.

4. Breathing New Life Into Existing Programs Can Lead To More Convenient, Direct Services And Increased Access For Consumers.

"Education and access are the most important needs of our citizens." Little Rock, AR

"Access to Health Care" is one of the Leading Health Indicators set forth in Healthy People 2010, the prevention agenda for our nation. Many profiles in this year's Lessons Learned outline the overhaul and/or expansion of existing programs to increase consumer access. Some streamline multiple services into one location, others expanded existing services into different, more convenient locations, or augmented hours of service, or increased home visits or added neighborhood clinics. All have the same goal in mind: to provide increased access to services for the populations they serve, and thereby impact health outcomes. As one reads the profiles, it is evident that public health departments work in consultation with consumer, to bring them needed products and services in more appropriate ways.

Winnebago County Health Department in Rockford, IL spent the last year expanding and at the same time, streamlining services targeted to provide support, education and assistance to at-risk populations, especially teen moms and moms receiving TANF. After initial staff resistance to change which is common no matter the endeavor; a shift slowly occurred. Arduous groundwork began to spark staff interest and earn their commitment. This shift, combined with the perception that clients now felt more motivated to participate, is crucial, as the health department struggles to meet the unique needs of consumers. *"Implementing an old program in a new way can breath life into the program,"* said the profile submitted by Rockford, IL.

The Pinellas County (FL) Health Department (PCHD) reviewed problems with its existing WIC program to determine how to make it more efficient and helpful to consumers. Administrative staff got together with consumers and brainstormed ways to break down barriers to service and to increase participation. They separated the two types of WIC appointments into different locations in one building so that those arriving simply to pick up checks no longer had prolonged wait time. They commented that, *"It is important to listen to consumers and act on the information they provide about service delivery. PCHD and the consumers worked together to identify and solve a problem and improve services."* This leads us to the next prevailing theme found in the 2001 submissions for Lessons Learned:

5. Successful Initiatives Recognize The Individuality Of The Populations They Serve, And Tailor Their Undertakings To Take Those Unique Characteristics Into Account.

"Ask teens what is missing from health education. Many non-traditional issues mentioned by teens can have a direct impact on their health and attitudes toward health. Address these issues in the information you provide."
Oklahoma City, OK

While the stated objective for the Salinas (CA) project was to reduce teen pregnancy, one of the strategies involved staff getting inside the world of the clients they were serving, and coming to an understanding of how these girls saw their potential life script. From that different vantage point, staff were then able to craft opportunities designed to enable the girls to find a new way of looking at their own possibilities. Because of this empathetic approach, staff were able to craft events upon which the girls could build an entirely new set of dreams. *"It was surprising to the staff how narrow the world is for these girls and young women. There were surprises as the girls were taken to the State Capitol, Stanford University and the University of California, Davis. This was a new world for them and the mentors saw a new world in their eyes."* Salinas, CA

The lesson learned here is that unless you take the time to know what your population thinks, feels, and believes, you cannot speak to them in a way that is meaningful. The Madison (WI) Department of Health took this lesson to heart as they developed a program to combat the a common misperception that oral health is not an essential part of a person's general health, *"The only way we have found to deal with this barrier is to inform and educate in a manner that respects the perspective and opinions of others."*

6. NEVER EVER UNDERESTIMATE THE USE OF DATA AS A POWERFUL TOOL FOR CHANGE.

"Tell the story. Tell the right story. Tell the right story right." Portland, ME

The effective use of data has emerged over the years as one of the more powerful tools that health departments can use. Used properly, data can explain not only what and where the problems are, but can be used to measure change, and to inform the public and key policymakers in a compelling fashion.

Said the Tacoma-Pierce County (WA) Health Department, *"By collecting this data, we hope to address these barriers and make prenatal care more readily accessible. In addition, a collaborative effort has been formed between local public health and the hospitals and high-risk families who were missed during the pregnancy are now being identified and linked to early intervention/prevention services."*

Marion County (OR) Health Department began a major focus to reduce teen pregnancy in 1997, when they found the rate to be at an all-time high. They needed to increase community awareness of the problem, and reduce the rate to at or below the state average of 18 percent. Thus began a program involving continuous monitoring of community health related data and of bringing relevant information to policy makers, commissioners, schools, churches and public agencies. The health department watched this strategy help unify their community to work toward the end objective of reducing teen pregnancy. They stated, *"Data is crucial to proving the significance of a health issue with long ranging effects."*

The Minneapolis (MN) Department of Health and Family Support brought this caveat forward to all who gather and analyze data in MCH: *"Communities want action, not simply more research."* And so the gentle reminder to health departments: gather the data, by all means, but make effective use of it. Data should be gathered and utilized as a tool for change, and *not* to be bound into another report gathering dust on a shelf, a lesson not lost on City**MatCH** member representatives.

7. PROGRAM EVALUATION IS A KEY STRATEGY FOR ENHANCING PROGRAM EFFECTIVENESS, GARNERING NEEDED SUPPORT AND RECOMMENDING PROGRAM REPLICATION.

"Multnomah County Health Department seeks to involve community partners at all stages of planning, implementation, and evaluation." Portland, OR

Doubtless, not all of the profiles submitted to *Lessons Learned* have been formally evaluated. Projects span a continuum from new initiatives still in the rollout phase all the way through established programs with formal evaluation mechanisms. Several profiles illustrate how evaluation processes led them to programmatic "tweaking" for enhanced outcomes. Others used outcome measurements as a tool to garner ongoing support from policymakers, city councils, foundations and grantmakers. Some discovered through implementing the project, the great need for evaluating program effectiveness. The key lesson learned submitted in one profile was this: *"We need a tracking system to evaluate how effective the training was and how the materials were utilized."*

Knowledge is power. The Black Infant Health Project of the Los Angeles County MCAH Program is addressing health disparities in birth outcomes of African-Americans compared to other racial/ethnic groups. They are able to have a very concise picture of project impact because of the excellent feedback from San Diego State University, who serves are the official evaluator of the Statewide Black Infant Health Programs.

Evaluation is an indispensable tool for Onondaga County (NY) Health Department developed the Syracuse Health Start Registry. For them, *"the essential element of evaluation as an ongoing tool in quality improvement activities has resulted in new policies and procedures relevant to the practice of preventive MCH, increasing the frequency of home visitation, improving the documentation of interventions and getting women into care earlier. Evaluation has also encouraged the refinement of data collection and improved the tracking and monitoring of registry participants."*

Good programs are meant to be shared. Collegial sharing and support is a hallmark of City**MatCH**. Peoria (IL) City-County Health Department commented in their profile that, *"as evaluation data is collected, the agency's "best practices" will be identified and profiled for possible replication."* They further describe sharing their local success and methodologies with pilot site colleagues and presenting it to State Level Department of Health staff.

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SUMMARY

CityMatCH recognizes that children and families in urban areas have unique needs that must be effectively addressed in order for all children, and ultimately our society, to achieve full potential. Through the sustained efforts of local public health agencies and the collaborative efforts they facilitate, they pave the way for improved health outcomes for children and families in urban areas. **CityMatCH** encourages the readers of this document to build on the Lessons Learned here in their own work in cities across America.

Annual Spotlights Recognition

Each year, peer reviewers read and critique all profiles submitted to City**MatCH**. As part of their review, nominations are made for three potential awards. Recognition is known as the *Spot***Light** Awards.

Selected for a *Spot***Light** in the area of **Alchemy** was the Baton Rouge (LA) Office of Public Health. This award is so named as a reference to a situation that appears grave but is turned around into opportunity and programmatic success, similar to turning lead into gold. Due to downsizing and standardization of State Government, the Baton Rouge Health Department lost seven clerical staff. These staff had processed Presumptive Eligibility (PE) applications for Medicaid benefits for pregnant women. At the same time the Parish of East Baton Rouge was recognized as having the second highest rate of Infant Mortality in the State. Turning this potentially disastrous situation around, the Office of Public Health successful increased the number of PE applications taken per week, thereby eliminating a significant barrier to accessing early prenatal care.

Durham County (NC) Health Department received the **Most Replicable** *Spot***Light** award for their program, "Together Everyone Accomplishes Something," (TEAS). TEAS works with teenage program participants and their parents, guardians or mentors, to delay initiation of sexual activity in teens, to promote contraceptive use in teens who are sexually active, to keep program participants enrolled satisfactorily in school and to prevent drug use among program participants. Their program success to date is great, and TEAS is a model that can be effectively recreated in other cities.

The unique Perinatal Infant – Parent Attachment Project of the Saint Paul – Ramsey County (MN) Department of Public Health drew the **Most Innovative** *Spot***Light** Award for providing prenatal support for families at high risk for unintended pregnancy, isolation, pregnancy after the loss of a previous baby, medically complicated pregnancy and insecure attachment between parent and child. Via a combination of Doula provision, attachment-enhancing activities such as guided videotaping, promotion of breastfeeding, relaxation through music and imagery, plus home-based services to high-risk families and other creative, effective strategies, Saint Paul-Ramsey Department of Public Health has created a successful, collaborative program to which participants are very receptive. Hats off to each of these three Health Departments for hard work on these and other programs they provide to women, children and families in their jurisdictions.

How to Use Profiles

What is a "profile"?

The annual City**Mat**C**H** Urban Maternal and Child Health (MCH) Leadership Conference is a working meeting of invited urban MCH leaders representing member city and county health departments whose jurisdictions include one or more cities with populations of 100,000 or more (or the largest city in states not otherwise represented). A requirement of each invited health department is to submit a written profile of one of the health department's MCH initiatives from the past year.

The profile includes a description of objectives, activities, barriers faced and overcome, health department roles, funding, accomplishments, and lessons learned (see sample on page 6). The designated MCH representative to City**Mat**C**H** may only receive federal subsidy for conference expenses if their profile is received prior to the Conference. Invited health departments are encouraged to submit a profile even if they are unable to send a representative to the Conference. Copies of profiles are included in the conference participant resource notebook to facilitate immediate peer exchange.

Why are "profiles" published?

Since 1992, in response to interest in and increasing demand for best practices in public health, City**Mat**C**H** has edited and published urban MCH profiles as a core component of Conference Highlights. The profiles are published as a compendium of ideas to promote the exchange of information about perceived successful initiatives in urban MCH. City**Mat**C**H** does not verify each profile, nor does it evaluate the initiative and efforts described. It is assumed that with the contact information provided, readers will follow up with the source health department to ask questions and secure essential additional information.

How are the "profiles" organized?

The profiles are presented in alphabetical order, by city and by state where the local health department is located. Each profile spans two pages, with standard headings for easy reference. Contact information is listed at the beginning of each profile to allow direct follow up with the health department. The 70 city and county health departments submitting profiles for the 2001 Urban MCH Leadership Conference are listed on page 5. In 1993, City**Mat**C**H** began to index the conference profiles using standard categories of MCH approaches and targeted MCH populations. This practice continues with the 2001 profiles. In addition, the 2001 profiles have been indexed by essential MCH program functions. Both Profiles Indexes, which appear on pages 10-21, are explained on the following page.

Using Profile Index I: Target Populations and Approaches

Profiles are listed in alphabetical order on the left margin, by city and by state where the health department is located. Each submitted urban MCH profile has been coded by City**Mat****CH** staff for up to 49 categories of activity. Categories applying to a profile are shaded across the row corresponding to the health department's city/state. Population-specific activities appear on the left-hand page; systems-specific approaches are indexed on the right-hand page. To determine all categories within a given profile, read across both pages. To identify the range of initiatives within a given approach, read up and down.

Using Profile Index II: Essential MCH Program Functions

Profiles are listed in alphabetical order on the left margin, by state and by city where the health department is located. Using the "Ten Essential MCH Functions Framework" developed by a working group of public health organizations under the direction of the John Hopkins University Child and Adolescent Health Policy Center, each health department coded its profile for up to 49 categories of MCH functions. The full list of functions appears on the sample profile form on the following two pages. MCH function categories applying to each profile are shaded in Profile Index II. To determine all MCH functions within a given profile, read across both pages in the row for its city/state. To identify the range of initiatives within a given MCH function, read up and down the columns, which have been numbered on top to allow ease in reading the index vertically. These numbers also correspond to the MCH functions listed on the sample profile. More information about the MCH Functions Framework can be found in the publication, "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America", prepared by Holly Allen Grason, MA and Bernard Guyer, MD MPH at the John Hopkins University Child and Adolescent Health Policy Center, for HRSA/MCHB, AMCHP, ASTHO, City**Mat****CH**, and NACCHO.

Comments and Feedback Welcome

City**Mat****CH** needs feedback on how these profiles are used and how useful they are to public health practice. Tell us your comments and let us know of your experiences using the City**Mat****CH** *Lessons Learned 2001* via E-mail: citymch@unmc.edu, or you may complete the evaluation form included with this publication and return it to: City**Mat****CH**, University of Nebraska Medical Center, Department of Pediatrics, 982170 Nebraska Medical Center, Omaha, NE 68198-2170.

Ten Essential Public Health Services to Promote Maternal and Child Health in America

1. Assess and monitor maternal and child health status to identify and address problems.
2. Diagnose and investigate health problems and health hazards affecting women, children and youth.
3. Inform and educate the public and families about maternal and child health issues.
4. Mobilize community partnerships between policy makers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.
5. Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families.
6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.
7. Link women, children and youth to health and other community and family services and assure quality systems of care.
8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs.
9. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services.
10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health related problems.

Source: Grason, H. and Guyer, B. (1995) "Public MCH Programs Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

Listing of Successful Leading Urban Health Department Initiatives in Maternal and Child Health

City**Mat**CH members attending the 2001 Urban MCH Leadership Conference were required to submit a profile outlining successful MCH initiatives. The profiles described objectives, partnerships, accomplishments, funding sources, barriers, and measures of success. The initiative did not have to involve direct service provision. A committee reviewed submitted profiles and presented a *Spot*Light award to those cities that created outstanding, innovative, and successful MCH initiatives. The 2001 *Spot*Light recipients are: Baton Rouge, LA, Durham, NC, and St. Paul, MN.

City/State	Page
Akron, OH	24
Baltimore, MD	26
Baton Rouge, LA	**28**
Berkeley, CA	30
Birmingham, AL	32
Boise, ID	34
Chicago, IL	36
Colorado Springs, CO	38
Columbia, SC	40
Columbus, OH	42
Corpus Christi, TX	44
Dallas, TX	46
Dayton, OH	48
Detroit, MI	50
Durham, NC	**52**
Evansville, TN	54
Fresno, CA	56
Golden, CO	58
Grand Rapids, MI	60
Greensboro, NC	62
Greenwood Village, CO	64
Hartford, CT	66
Indianapolis, IN	68
Jackson, MS	70
Knoxville, TN	72
Lexington, KY	74
Little Rock, AR	76
Long Beach, CA	78
Los Angeles, CA	80
Madison, WI	82
Miami, FL	84
Minneapolis, MN	86
Missoula, MT	88
Mobile, AL	90
Modesto, CA	92
Nashville, TN	94
New Haven, CT	96
Newark, NJ	98
Norfolk, VA	100
Oklahoma City, OK	102
Omaha, NE	104
Peoria, IL	106
Philadelphia, PA	108
Phoenix, AZ	110
Pittsburgh, PA	112
Portland, ME	114
Portland, OR	116
Providence, RI	118
Raleigh, NC	120
Rochester, NY	122
Rockford, IL	124
Saint Paul, MN	**126**
Saint Petersburg, FL	128
Salem, OR	130
Salinas, CA	132
Salt Lake City, UT	134
San Antonio, TX	136
San Diego, CA	138
San Francisco, CA	140
Sanford, FL	142
Santa Rosa, CA	144
Seattle, WA	146
Spokane, WA	148
Syracuse, NY	150
Tacoma, WA	152
Tucson, AZ	154
Tulsa, OK	156
Waco, TX	158
Washington, DC	160
Wilmington, DE	162

Instructions for 2001 City**MatCH** Member Urban MCH Profiles

Each year City**MatCH** members are asked to profile a successful MCH effort in their community. This year you also have the option of submitting a 'pearl' - something that started out as an irritant but you worked on it until it was a thing of beauty! A pearl may be a hard-learned lesson or a bad idea that did some good after all.

Any recent innovative program, activity or lesson learned *not previously submitted* which has strengthened your capacity to serve children and families can be submitted. There will be three awards this year: Most Innovative, Most Replicable, and the Alchemy Award for turning lead into gold!

Activities do not have to be a program or involve direct service provision.

While you are welcome to attach additional documents, we ask that you use the attached form. Profiles will be provided to all conference participants and reproduced in the City**MatCH** publication, "*Lessons Learned 2001: Profiles of Urban Health Department MCH Efforts.*"

Thank you for completing the 2001 Urban MCH Leadership Conference profile. If you have any questions or comments, please contact the City**MatCH** Central Office at (402) 561-7500.

To receive financial assistance CityMatCH members must complete and submit a Profile or Pearl prior to or upon registration at the Conference.

Please Mail, FAX or E-Mail Completed Profile by Friday, August 10 to:

City**MatCH** at University of Nebraska Medical Center
Department of Pediatrics
982170 Nebraska Medical Center
Omaha, NE 68198-2170
Phone: (402) 561-7500
FAX: (402) 561-7525
E-Mail: CityMCH@unmc.edu

Profiles received by Friday, August 10, 2001 will be included in conference materials and will be eligible for Spot*Lights* recognition.

Profiles must be typed. Handwritten submissions will not be accepted.

Health Department: ______________________ City: ______________ State: ________

City**MatCH** Representative: ______________________ Title: ______________________

Phone: (___) ______________ For more information contact: ______________________

(If other than CityMatCH Representative)

Activity Name:____

Please consider my profile for (√ one): ☐ **Most Innovative** ☐ **Most Replicable** ☐ **Alchemy Award**

Please circle **ONLY THOSE** MCH functions that best apply to your "Activity," either Profile or Pearl.

Women's Health
1 Preconception promotion
2 Family planning
3 Breast/cervical cancer

Perinatal Health
4 Prenatal care
5 Expanding maternity services
6 Home visiting
7 Low birthweight/infant mortality
8 Substance abuse prevention
9 Breastfeeding/nutrition/WIC

Child Care
10 Immunizations
11 Early intervention/zero to three
12 EPSDT/screenings
13 Expanded child health services
14 Injury (including child abuse)
15 Lead poisoning
16 Children with special needs
17 School-linked/based services

Adolescent Health
18 School-linked/based services
19 Violence prevention/at risk
20 Teen pregnancy
21 Teen parenting

Other
22 Communicable diseases
23 Family violence
24 Dental programs

Improving Access to Care for Urban Children and Families
25 Overcoming cultural barriers
26 Reducing transportation barriers
27 Expanding private sector links
28 Clergy & health connections
29 Schools & health connections
30 One-stop shopping locations
31 Mobile clinics for outreach
32 Other outreach activities
33 Increasing social support
34 Case coordination
35 Increasing access to Medicaid

Strengthening Urban Public Health Systems for MCH
36 Staff training
37 Strategic planning
38 Reshaping urban MCH
39 Securing MCH assistance
40 Managed care initiatives
41 Building coalitions & partnerships
42 Building MCH data capacity
43 Immunization tracking/recall
44 Infant/child death review

45 **Other** (please specify)
____
____
____
____
____
____

2001 CityMatCH Urban MCH Profile

Activity Name: ______________________ Health Dept: ______________
Contact: ______________________ City/State: ______________

Please circle **ONLY THOSE** "MCH Functions*" that best apply to your "Activity," either Profile or Pearl.

Assess MCH Status

1 Develop tools standardizing data collection, analysis, reporting
2 Implement public MCH program client data systems
3 Analysis of demographics, economic status, behaviors, health status
4 Community perceptions of health problems/needs

Diagnose/Investigate Occurrence of Problems & Hazards

5 Tracking systems
6 Population surveys (BRFS, PRAMS, PedNSS, YRBS)
7 Environmental assessments
8 Maternal, fetal/infant, child death reviews

Promoting Positive Beliefs, Attitudes, Behaviors

9 Hotlines, print materials, media campaigns
10 Culturally appropriate health education materials/programs
11 Implement/support education services for special MCH problems
12 Assessment of provider reports regarding process and outcomes

Community Partnerships

13 Prepare, publish & distribute reports
14 Public advocacy for legislation & resources

Research/Demonstration Projects

15 Special studies
16 Development of models

Assess Community Priorities & Action Plans

17 Develop & promote MCH agenda & YR2000 National Objectives
18 Newsletters, convening focus groups, advisory committees, networks
19 Promote compatible, integrated service system initiatives

Promote, Enforce Laws, Regulations, Standards, Contracts (LRSC)

20 Consistent, coordinated policies across programs
21 MCH input in legislative base for health plans & standards
22 MCH legislative activity
23 Development, promulgation, review, updating LRSC
24 Certification & monitoring provider compliance
25 Professional license & certification process
26 Monitor MCO marketing practices
27 Ombudsman services

Assure Capacity/Competency of Public Health Work Force

28 Provide infrastructure/capacity for MCH functions
29 Staff training
30 Support of continuing education
31 Support of health plans/provider networks
32 Health care labor force analysis
33 Laboratory capacity

Link MCAH Population to Services

34 Provide outreach services
35 Transportation & other access-enabling services
36 Referral systems, resource directories, advertising, enrollment assistance
37 Monitor enrollment practices for ease of use
38 Identify high-risk/hard-to-reach populations & methods to serve them
39 Provide, arrange, administer direct services
40 Universal newborn screening programs
41 Detention settings, foster care, mental health facilities
42 Prior authorization for out-of-plan specialty services
43 Review process for pediatric LT care admissions, CSHCN home services
44 Managed Care model contracts & access issues
45 Pediatric risk adjustment methods & payment mechanisms
46 Identify alternative resources to expand system capacity

Evaluate Effectiveness, Accessibility, & Quality of MCH Services

47 Comparative analysis of HC delivery systems
48 Profiles of provider attitudes, knowledge & practices
49 Identify & report access barriers

50 **Other** (please specify):
____
____
____
____

*Source: Grason, H. And Guyer, B. (1995) "Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD

BEST COPY AVAILABLE

2001 CityMatCH Urban MCH Profile

Activity Name: ______________________ Health Dept: ______________
Contact: ______________________ City/State: ______________

Please describe the activity:

Please describe the activity's objectives (specific, measurable):

Greatest barrier(s) facing implementation:

How are these barriers being overcome?

2001 CityMatCH Urban MCH Profile

Activity Name: ______________________ Health Dept: ______________________
Contact: ______________________ City/State: ______________________

How is the activity funded?

☐ City/County/Local government funds
☐ General state funds
☐ MCH block grant funds
☐ SPRANS funds
☐ Private source(s): Please specify:
____
____

☐ 330 funds
☐ *Other Federal funds*
☐ Third party reimbursement (Medicaid, insurance)
☐ Other: Please specify:
____
____

Approximate annual budget: $______________________

In planning, implementing and evaluating this activity, what has been the role of your health department?

Has this activity been formally evaluated?

☐ Yes
☐ No
☐ Don't know

Has this activity been replicated elsewhere?

☐ Yes
☐ No
☐ Don't know

What are the major accomplishments to date?

What are the lessons learned?

Profile Index I

2001 Urban Health Department MCH Efforts

by type of initiative

		Women's Health			Perinatal Health						Child Health								Other			
		Preconception promotion	Family planning	Breast/cervical cancer	Prenatal care	Expanding maternity services	Home visiting	Low birthweight/infant mortality	Substance abuse prevention	Breastfeeding/nutrition/WIC	Immunizations	Early intervention/zero to three	EPSDT/screenings	Expanded child health services	Injury (including child abuse)	Lead poisoning	Children with special needs	School-linked/based services	School-linked/based services	Violence prevention/at risk	Teen pregnancy	Teen parenting
City, State	Page	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Akron, OH	24																					
Baltimore, MD	26																					
Baton Rouge, LA	28					■		■														
Berkeley, CA	30																					
Birmingham, AL	32																		■			
Boise, OH	34										■											
Chicago, IL	36									■												
Colorado Springs, CO	38	■	■		■		■	■													■	
Columbia, SC	40										■											
Columbus, OH	42				■						■											
Corpus Christi, TX	44																					
Dallas, TX	46																	■	■			■
Dayton, OH	48																					
Detroit, MI	50									■		■	■			■						
Durham, NC	52	■	■						■										■	■	■	
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Fresno, CA	56														■					■		
Golden, CO	58										■											
Grand Rapids, MI	60									■												■
Greensboro, NC	62					■	■															
Greenwood Village, CO	64		■																			
Hartford, CT	66						■									■						
Indianapolis, IN	68						■															
Jackson, MS	70	■	■		■	■	■	■	■	■												
Knoxville, TN	72				■																	
Lexington, KY	74	■	■		■		■	■	■	■	■	■	■	■							■	
Little Rock, AR	76																				■	■
Long Beach, CA	78										■											
Los Angeles, CA	80		■		■	■	■	■	■	■	■	■	■	■	■	■	■				■	■
Madison, WI	82																					
Miami, FL	84									■												
Minneapolis, MN	86		■					■													■	
Missoula, MT	88									■								■	■			

Source: Grason, H. and Guyer, B. (1995) "Public Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD.

Profile Index I	Improving Access to Care for Urban Children and Families														Strengthening Urban Public Health Systems for MCH								
2001 Urban Health Department MCH Efforts by type of initiative	Communicable diseases	Family violence	Dental programs	Overcoming cultural barriers	Reducing transportation barriers	Expanding private sector links	Clergy & health connections	Schools & health connections	One-stop shopping locations	Mobile clinics for outreach	Other outreach activities	Increasing social support	Case coordination	Increasing access to Medicaid	Staff training	Strategic planning	Reshaping urban MCH	Securing MCH assistance	Managed care initiatives	Building coalitions & partnerships	Building MCH data capacity	Immunization tracking/recall	Infant/child death review
City, State	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44
Akron, OH			■																				
Baltimore, MD																					■		
Baton Rouge, LA						■			■					■									
Berkeley, CA																							
Birmingham, AL	■							■												■			
Boise, OH						■					■									■		■	
Chicago, IL															■								
Colorado Springs, CO									■		■												
Columbia, SC																						■	
Columbus, OH				■																			
Corpus Christi, TX								■													■		
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Dayton, OH				■		■	■				■	■				■				■			
Detroit, MI											■			■	■		■			■			
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Los Angeles, CA		■		■	■	■	■	■	■	■	■	■	■	■									
Madison, WI			■	■		■		■			■				■	■				■			
Miami, FL																							
Minneapolis, MN				■												■							
Missoula, MT						■	■	■							■					■			

Source: Grason, H. and Guyer, B. (1995) "Public Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD.

Profile Index I

2001 Urban Health Department MCH Efforts

by type of initiative

		Women's Health			Perinatal Health						Child Health								Other			
	Page	Preconception promotion	Family planning	Breast/cervical cancer	Prenatal care	Expanding maternity services	Home visiting	Low birthweight/infant mortality	Substance abuse prevention	Breastfeeding/nutrition/WIC	Immunizations	Early intervention/zero to three	EPSDT/screenings	Expanded child health services	Injury (including child abuse)	Lead poisoning	Children with special needs	School-linked/based services	School-linked/based services	Violence prevention/at risk	Teen pregnancy	Teen parenting
City, State		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Mobile, AL	90							■														
Modesto, CA	92		■																		■	
Nashville, TN	94											■										
New Haven, CT	96	■			■		■	■			■										■	■
Newark, NJ	98		■	■				■	■	■					■	■	■			■	■	
Norfolk, VA	100																	■	■	■		
Oklahoma City, OK	102																					
Omaha, NE	104									■							■					
Peoria, IL	106				■	■	■	■													■	
Philadelphia, PA	108																					
Phoenix, AZ	110				■	■		■													■	
Pittsburgh, PA	112																					
Portland, ME	114										■		■					■	■		■	
Portland, OR	116																					
Providence, RI	118												■			■						
Raleigh, NC	120		■		■								■	■								
Rochester, NY	122																				■	
Rockford, IL	124					■		■		■	■										■	■
Saint Paul, MN	126				■	■	■															
Saint Petersburg, FL	128																					
Salem, OR	130		■																		■	
Salinas, CA	132	■																			■	
Salt Lake City, UT	134																					
San Antonio, TX	136			■																		
San Diego, CA	138																					
San Francisco, CA	140																					
Sanford, FL	142		■		■	■	■	■		■												
Santa Rosa, CA	144																					
Seattle, WA	146				■			■														
Spokane, WA	148				■	■						■	■	■			■					
Syracuse, NY	150		■		■		■	■	■	■		■		■		■	■		■	■	■	■

Source: Grason, H. and Guyer, B. (1995) "Public Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD.

Profile Index I	Improving Access to Care for Urban Children and Families														Strengthening Urban Public Health Systems for MCH								
2001 Urban Health Department MCH Efforts by type of initiative	Communicable diseases	Family violence	Dental programs	Overcoming cultural barriers	Reducing transportation barriers	Expanding private sector links	Clergy & health connections	Schools & health connections	One-stop shopping locations	Mobile clinics for outreach	Other outreach activities	Increasing social support	Case coordination	Increasing access to Medicaid	Staff training	Strategic planning	Reshaping urban MCH	Securing MCH assistance	Managed care initiatives	Building coalitions & partnerships	Building MCH data capacity	Immunization tracking/recall	Infant/child death review
City, State	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	27	28	[illegible]	[illegible]	[illegible]	[illegible]	33	[illegible]	[illegible]	36	37	38	39	40	41	42	43	44
Mobile, AL																							
Modesto, CA						■	■					■						■		■			
Nashville, TN			■					■															
New Haven, CT				■									■	■	■		■			■	■		■
Newark, NJ	■			■			■	■			■	■			■	■		■		■	■		
Norfolk, VA		■						■				■	■		■	■				■			
Oklahoma City, OK								■												■			
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Philadelphia, PA				■											■								
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Providence, RI												■								■	■		
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Rochester, NY								■												■			
Rockford, IL					■				■		■		■							■			
Saint Paul, MN				■								■	■		■					■			
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Santa Rosa, CA																							
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Spokane, WA			■	■	■	■						■	■	■	■	■		■		■			
Syracuse, NY	■	■		■	■	■	■	■			■	■	■	■	■	■	■	■	■	■	■		■

Source: Grason, H. and Guyer, B. (1995) "Public Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD.

Profile Index I		Women's Health			Perinatal Health						Child Health								Other			
2001 Urban Health Department MCH Efforts by type of initiative	Page	Preconception promotion	Family planning	Breast/cervical cancer	Prenatal care	Expanding maternity services	Home visiting	Low birthweight/infant mortality	Substance abuse prevention	Breastfeeding/nutrition/WIC	Immunizations	Early intervention/zero to three	EPSDT/screenings	Expanded child health services	Injury (including child abuse)	Lead poisoning	Children with special needs	School-linked/based services	School-linked/based services	Violence prevention/at risk	Teen pregnancy	Teen parenting
City, State		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Tacoma, WA	152						■		■											■	■	■
Tucson, AZ	154																					
Tulsa, OK	156																					
Waco, TX	158																					
Washington, DC	160				■																	
Wilmington, DE	162	■			■																	

Source: Grason, H. and Guyer, B. (1995) "Public Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD.

Profile Index I	Improving Access to Care for Urban Children and Families														Strengthening Urban Public Health Systems for MCH								
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City, State	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44
Tacoma, WA		▨											▨	▨									
Tucson, AZ											▨												
Tulsa, OK																							▨
Waco, TX																				▨			
Washington, DC																				▨			
Wilmington, DE																							

Source: Grason, H. and Guyer, B. (1995) "Public Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD.

Profile Index II

2001 Urban Health Department MCH Efforts

by essential function

		Asses MCH Status				Diagnose Problems and Hazards				Promote Positive Attitudes and Behaviors				Community Partners		Research/ Demo		Assess Priorities and Plans			Promote, Enforce LRSC				
	Page	Develop tools standardizing data collection, analysis, reporting	Implement public MCH program client data systems	Analysis of demographics, economic status, behaviors, health status	Community perceptions of health problems/needs	Tracking systems	Population surveys (BRFS, PRAMS, PedNSS, YRBS)	Environmental assessments	Maternal, fetal/infant, child death reviews	Hotlines, print materials, media campaigns	Culturally appropriate health education materials/programs	Implement/support education services for special MCH problems	Assessment of provider reports regarding process and outcomes	Prepare, publish & distribute reports	Public advocacy for legislation & resources	Special studies	Development of models	Develop & promote MCH agenda &YR2010 National Objectives	Newsletters, convening focus groups, advisory committees, networks	Promote compatible, integrated service systems initiatives	Consistent, coordinated policies across programs	MCH input in legislative base for health plans & standards	MCH legislative activity	Development, promulgation, review, updating LRSC	Certification & monitoring provider compliance
City, State		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Akron, OH	24																								
Baltimore, MD	26	■		■		■		■						■			■								
Baton Rouge, LA	28																								
Berkeley, CA	30				■															■					
Birmingham, AL	32												■			■	■								
Boise, OH	34			■						■						■	■								
Chicago, IL	36										■	■													
Colorado Springs, CO	38																								
Columbia, SC	40					■																			
Columbus, OH	42			■	■						■														
Corpus Christi, TX	44				■		■									■			■						
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Dayton, OH	48									■															
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Durham, NC	52					■				■	■						■		■						
Evansville, IN	54				■							■													
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Golden, CO	58			■																					
Grand Rapids, MI	60	■				■						■		■			■								
Greensboro, NC	62																								
Greenwood Village, CO	64											■					■	■							
Hartford, CT	66									■	■														
Indianapolis, IN	68		■											■				■							

Source: Grason, H. and Guyer, B. (1995) "Public Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD.

Profile Index II	Promote, Enforce LRSC			Assure Capacity of Public Health Workforce					Link MCAH Population Services														Evaluate Quality of MCH Services		
2001 Urban Health Department MCH Efforts by essential function	Professional license & certification process	Monitor MCO marketing practices	Ombudsman services	Provide infrastructure/capacity for MCH functions	Staff training	Support of continuing education	Support of health plans/provider networks	Health care labor force analysis	Laboratory capacity	Provide outreach services	Transportation & other access-enabling services	Referral systems, resource directories, advertising, enrollment assistance	Monitor enrollment practices for ease of use	Identify high-risk/hard-to-reach populations & methods to serve them	Provide, arrange, administer direct services	Universal newborn screening programs	Detention setting, foster care, mental health facilities	Prior authorization for out-of-plan specialty services	Review process for pediatric LT care admissions, CSHCN home services	Managed Care model contracts & access issues	Pediatric risk adjustment methods & payment mechanisms	Identify alternative resources to expand system capacity	Comparative analysis of HC delivery systems	Profiles of provider attitudes, knowledge & practices	Identify & report access barriers
City, State	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
Akron, OH															■							■			
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Profile Index II

2001 Urban Health Department MCH Efforts

by essential function

City, State	Page	Asses MCH Status				Diagnose Problems and Hazards				Promote Positive Attitudes and Behaviors				Community Partners		Research/ Demo		Assess Priorities and Plans			Promote, Enforce LRSC				
		Develop tools standardizing data collection, analysis, reporting	Implement public MCH program client data systems	Analysis of demographics, economic status, behaviors, health status	Community perceptions of health problems/needs	Tracking systems	Population surveys (BRFS, PRAMS, PedNSS, YRBS)	Environmental assessments	Maternal, fetal/infant, child death reviews	Hotlines, print materials, media campaigns	Culturally appropriate health education materials/programs	Implement/support education services for special MCH problems	Assessment of provider reports regarding process and outcomes	Prepare, publish & distribute reports	Public advocacy for legislation & resources	Special studies	Development of models	Develop & promote MCH agenda &YR2010 National Objectives	Newsletters, convening focus groups, advisory committees, networks	Promote compatible, integrated service systems initiatives	Consistent, coordinated policies across programs	MCH input in legislative base for health plans & standards	MCH legislative activity	Development, promulgation, review, updating LRSC	Certification & monitoring provider compliance
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
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Knoxville, TN	72				■							■													
Lexington, KY	74										■							■							
Little Rock, AR	76																								
Long Beach, CA	78										■									■					
Los Angeles, CA	80	■								■	■	■													
Madison, WI	82			■	■					■	■	■		■	■				■	■					
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Minneapolis, MN	86			■										■	■	■									
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Mobile, AL	90																								
Modesto, CA	92																								
Nashville, TN	94										■														
New Haven, CT	96		■						■	■	■			■						■					
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Norfolk, VA	100	■			■					■				■		■				■					
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Portland, OR	116																								

Source: Grason, H. and Guyer, B. (1995) "Public Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD.

Profile Index II

2001 Urban Health Department MCH Efforts

by essential function

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	Professional license & certification process	Monitor MCO marketing practices	Ombudsman services	Provide infrastructure/capacity for MCH functions	Staff training	Support of continuing education	Support of health plans/provider networks	Health care labor force analysis	Laboratory capacity	Provide outreach services	Transportation & other access-enabling services	Referral systems, resource directories, advertising, enrollment assistance	Monitor enrollment practices for ease of use	Identify high-risk/hard-to-reach populations & methods to serve them	Provide, arrange, administer direct services	Universal newborn screening programs	Detention setting, foster care, mental health facilities	Prior authorization for out-of-plan specialty services	Review process for pediatric LT care admissions, CSHCN home services	Managed Care model contracts & access issues	Pediatric risk adjustment methods & payment mechanisms	Identify alternative resources to expand system capacity	Comparative analysis of HC delivery systems	Profiles of provider attitudes, knowledge & practices	Identify & report access barriers
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Profile Index II

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by essential function

		Asses MCH Status				Diagnose Problems and Hazards				Promote Positive Attitudes and Behaviors				Community Partners		Research/ Demo		Assess Priorities and Plans			Promote, Enforce LRSC				
	Page	Develop tools standardizing data collection, analysis, reporting	Implement public MCH program client data systems	Analysis of demographics, economic status, behaviors, health status	Community perceptions of health problems/needs	Tracking systems	Population surveys (BRFS, PRAMS, PedNSS, YRBS)	Environmental assessments	Maternal, fetal/infant, child death reviews	Hotlines, print materials, media campaigns	Culturally appropriate health education materials/programs	Implement/support education services for special MCH problems	Assessment of provider reports regarding process and outcomes	Prepare, publish & distribute reports	Public advocacy for legislation & resources	Special studies	Development of models	Develop & promote MCH agenda &YR2010 National Objectives	Newsletters, convening focus groups, advisory committees, networks	Promote compatible, integrated service systems initiatives	Consistent, coordinated policies across programs	MCH input in legislative base for health plans & standards	MCH legislative activity	Development, promulgation, review, updating LRSC	Certification & monitoring provider compliance
City, State		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Providence, RI	118			■	■			■							■	■							■		
Raleigh, NC	120																								
Rochester, NY	122				■					■	■			■			■								
Rockford, IL	124											■						■		■					
Saint Paul, MN	126																								
Saint Petersburg, FL	128																								
Salem, OR	130			■	■		■			■		■													
Salinas, CA	132										■	■													
Salt Lake City, UT	134	■	■	■	■		■		■	■	■	■	■	■		■		■			■				
San Antonio, TX	136																			■					
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Tulsa, OK	156				■				■																
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Washington, DC	160																■			■					
Wilmington, DE	162											■													

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Profile Index II	Promote, Enforce LRSC			Assure Capacity of Public Health Workforce					Link MCAH Population Services														Evaluate Quality of MCH Services		
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Source: Grason, H. and Guyer, B. (1995) "Public Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America," Johns Hopkins University Child and Adolescent Health Policy Center, Baltimore, MD.

2001 Successful Urban Health Department Initiatives in Maternal and Child Health

Safety Net Dental Clinic

Christine R. Johnson, RN, MS
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City of Akron Health Department
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Akron, OH 44308
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Replicated: Don't Know
Evaluated: No

For additional information, please contact:
Greg Ervin (330) 375-2369

Essential MCH Functions:	MCH Initiatives
Dental programs	Provide, arrange, administer direct services Identify alternative resources to expand system capacity

Description

Implement a full-time Safety Net Dental Clinic providing both preventive and restorative dental care. Staff will consist of one full-time dentist, two part-time dental hygienists, two dental assistants, and one support staff member. Clinic is scheduled to open prior to the end of 2001.

Objectives

At least 750 clients will receive dental services during the first year of operation. Client population will consist of the uninsured/underinsured, Medicaid recipients, and clients who will pay-based on a sliding fee scale. The number of Summit County residents receiving preventive/restorative dental care will increase over time to more closely approximate the Healthy People 2010 Oral Health Objectives. Clinic will continue to operate after the initial funding has been exhausted; management will gradually be transferred to the local federally qualified health center.

Of the $310,000 received from the Tobacco Settlement, approximately $110,000 will be used for renovating the existing space, $60,000 will be needed for equipment, with the remainder allocated for salaries.

Barriers Encountered

While the need for a dental clinic has been well documented over time, funding such an activity was probably the greatest barrier. Also, a suitable location had to be secured.

Strategies to Overcome

The Summit County Dental Task Force includes representatives from the Summit County General Health District, the Akron City Health Department, The Healthy Connections Network, the Ohio Department of Health, The University of Akron College of Nursing, the Case Western Reserve University School of Dentistry, The Dental OPTIONS Program, the Akron Community Resources Clinic, and a private dentist. The Akron Community Resources Clinic is a federally qualified health center and the Task Force is hopeful that this clinic will be able to secure additional federal funding to include the Safety Net Dental Clinic under its umbrella. The dental clinic and the federally qualified health center are located in the same block of offices; there is ample free parking and easy access to public transportation.

Funding Source: Other
Description of other sources: Tobacco Settlement Money
Budget: $250,000.00

Role of Health Department:

The health department is a member of the Summit County Dental Task Force and was instrumental in bringing about this activity. The department has very close ties with the federally qualified health center which helped in securing a very suitable location for the clinic. The department has been and remains involved in all phases of the planning and implementation.

Accomplishments:
Securing funding was a major accomplishment. This was possible because of all the ground work the Task Force had performed prior to applying for funding from the tobacco settlement money. Turf issues were laid aside in order to bring about this much needed service.

Lessons Learned:
The initial lesson was that "two heads are better than one," or as in this case, several heads. Much can be accomplished through teamwork and focusing on a common goal.

Baltimore Asthma Surveillance System

Lisa Firth, MB, MPH
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Division of Maternal & Child Health
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Replicated: No
Evaluated: No

For additional information, please contact:
Ruth Quinn (410) 396-1834

Essential MCH Functions:	MCH Initiatives
Building MCH data capacity	Tracking systems Environmental assessments Prepare, publish & distribute reports Development of models Identify & report access barriers

Description

The Baltimore City Health Department convened a team to establish the Baltimore Asthma Surveillance System (BASS). This effort was furthered by selection for participation in the Data Use Institute. Researchers and clinicians, representatives from the State health department, the school health program, community groups, and other potential end users of the system were involved. The project team has worked to identify relevant data sets and determine accessibility of these data sets. The project's first report on pediatric hospitalizations in Baltimore has been published.

Objectives

1. Design and implement an asthma surveillance system to collect and integrate data for Baltimore City.
2. Promote the use of information from the asthma surveillance system by health departments, researchers, clinicians, policy makers, and other interested parties.
3. Evaluate the effectiveness of the asthma surveillance system.
4. Serve as a prototype for regional and national asthma surveillance efforts.

Barriers Encountered

The two greatest barriers facing full implementation of BASS were difficulty gaining access to data and lack of funding for dedicated personnel and computer hardware and software.

Strategies to Overcome

Health department personnel have sought out the "keepers" of data sets that are needed for the surveillance system and endeavored to form good working relationships with them. In the absence of funding for dedicated staff, a preventive medicine resident and a graduate student intern were used to move the project forward. At the same time, all available grant opportunities were pursued.

Funding Source: Other Federal
Description of other sources: No dedicated funding for staff yet. Small federal grant for software and statistician consultation.
Budget: $0.00

Role of Health Department:

The health department has coordinated this activity and spearheaded efforts to find resources to sustain it.

Accomplishments:

Publication of a childhood asthma hospitalization report for Baltimore City.

Lessons Learned:

While much can be planned and set in motion by skilled and committed volunteers, dedicated funding for staff is needed for an ambitious project such as this to move forward.

P.E. Applications

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Fax: (225) 925-7245
E-mail: jroques@dhh.state.la.us

Replicated: Don't Know
Evaluated: No

Essential MCH Functions:	**MCH Initiatives**
Expanding maternity services Low birthweight/infant mortality Expanding private sector links One-stop shopping locations Increasing access to Medicaid	Referral systems, resource directories, advertising, enrollment assistance Identify & report access barriers

Description

East Baton Rouge Parish has an African American Infant Mortality Rate of 17.0, the second highest in the state. Last calendar year, this parish lost seven clerical personnel as a result of downsizing and standardization of State government. The staff in this health unit serve approximately 36,000 unduplicated clients per year. Prior to this, the clerical and nursing staff processed Presumptive Eligibility (P.E.) applications for Medicaid benefits every Friday afternoon for pregnant women. An average of 40 applications were taken per week. All of the private providers affiliated with Woman's Hospital accept a P.E. card for prenatal services.

The impact of the decrease in staff was significant and resulted in setting a limit on the number of applications that could be processed. The maximum number was set at 17, which meant that approximately 23 women per week would have to delay obtaining prenatal medical appointments. No other agency in the State is authorized to do P.E. according to the state's Medicaid regulations. Therefore, we were faced with the following dilemma: a State agency authorized to address infant mortality, serving an area with the second highest infant mortality in the State and the realization that we had a self-imposed barrier to accessing early prenatal care.

East Baton Rouge Parish implemented the following:

1. The Medicaid program agreed to send one person to the health unit all day on Fridays to process P.E. applications. While at this site, she worked under the Office of Public Health.
2. MCH contracted with a branch facility of the health unit, Family Road for one FTE to process P.E. applications.

Objectives

1. Increase local capacity to process 40 or more prenatal Medicaid applications per week.
2. Eliminate one barrier to accessing early prenatal care.

Barriers Encountered

1. Funding for human resources.
2. Standardization guidelines-based on staffing ratios of one clerical FTE to 3000.

Strategies to Overcome

We contacted the MCH Director and requested that she contract with Family Road to hire one full-time person to process P.E. applications, as a complete Medicaid application was already being provided at this site.

We also negotiated with the State Medicaid office to send us an eligibility determination worker every Friday to assist us in meeting the demand for insurance for prenatal care.

Funding Source: Other Federal, MCH block grant funds
Budget: $24,000.00

Role of Health Department:

We initiated the conversations with the Medicaid and MCH offices. We presented the issue along with proposed solutions and assumed the data collections activities. We also provide office space and supplies, along with assistance as needed.

Accomplishments:
40-50 applications are processed each week at the East Baton Rouge Parish Health Unit. All eligible applications are referred to a prenatal care provider at that time. The Family Road expansion has not started as the contract was only recently approved.

Lessons Learned:
1. Sometimes one can unintentionally become a barrier to accessing timely services for a priority program one is primarily responsible for providing.
2. It takes less investment of resources to meet demands when resources are pooled or shared.
3. For an annual cost of $24,000, 1196 women are given the opportunity to receive early prenatal care, and the numbers will only increase once the Family Road initiative begins.
4. Always keep your eye on the big picture.

Community Capacity Building

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Fax: (510) 644-6494
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Replicated: Yes
Evaluated: No

For additional information, please contact:
Poki Namkung (510) 665-6802

Essential MCH Functions:	MCH Initiatives
Community Capacity Building	Community perceptions of health problems/needs Promote compatible, integrated services system initiatives Community Organizing to Improve MCAH Health Outcome

Description

In April 2000 a Town Hall meeting sponsored by County Supervisor Keith Carson and Congresswoman Barbara Lee was held. Also present were Assemblywoman Dion Aroner, Mayor Shirley Dean and four city council members. The community residents overwhelmingly decided to continue to work around the issue of Health Disparities, in particular, low birthweight disparity between African American and White populations of Berkeley. The residents established Community Action Teams (CATs) in two areas of Berkeley that had been identified as at high risk for health disparities: South Berkeley and West Berkeley. These CATs have met monthly for over a year. The Maternal, Child and Adolescent Health (MCAH) program facilitated this process and provided technical assistance in its growth.

Objectives

Engage in community capacity building to improve selected health outcomes over a ten year period. In the first year, the MCAH Program will take the lead in activities to build community interest and promote community solutions to community identified problems, including:
1. Creating forums, small groups and other means to elicit the strengths of community members in identifying and proposing solutions to problems that they experience (lists and minutes are on file).
2. Involving community residents in the methods of community assessment through a community identified method training.
3. Reviewing instruments for data collection (survey tools designed by residents with technical assistance from MCAH staff and epidemiologists familiar with participatory action research).
4. Comparing action-planning processes and identifying appropriate methods (work plan).
5. Creating an inventory of community assets in South and West Berkeley.

Barriers Encountered

The largest obstacle in launching this project has been the city bureaucracy. The administrative systems and protocols could not be flexible enough to rapidly respond to the community. Identifying appropriate staff to be the community organizers for this project took time. The criteria for the organizers was developed by the Community Action Teams and included the following: a resident of the identified area, representative of the racial and ethnic make up of the area and in one instance bilingual/bicultural. A last significant barrier was to identify 20 residents to be trained in community capacity building techniques. There were many more than we could pay. Some applicants wanted to volunteer and some wanted to participate just to learn and not be responsible for the continuing organizing effort.

Strategies to Overcome

Backing from the city leaders helped to break through some of the bureaucracy. But perseverance and "doggedness" on the part of MCAH staff was critical. We did not take "no" for an answer. It was clear that this was a new process for many of those involved and we were led up many a blind alley before resolution. Residents were involved in a democratic process of selection of the organizers and the resident interns. There was only one serious incident where a substantive portion of a community meeting (with about 35 individuals present) was devoted to resentment that the process was not fair. However, through that meeting it became clear that not only was the process fair and just, but the other residents in the room agreed with the choices.

Funding Source: Local Government, MCH block grant funds
Budget: $250,000.00

Role of Health Department:
The Maternal, Child and Adolescent Health Program hired a Director of Community Capacity Building to spearhead this project. There was accord from the Health Officer and other critical leaders in public health from the beginning. It was recognized that to address the issue of racial and ethnic health disparities, this effort at organizing the community was just as critical as the service effort of public health overall. Likewise, the implementation of the program was mainly through MCAH staff. However, the evaluation of the project is with the community residents.

Accomplishments:
The Community Action Teams identified a successful model of prevention using community capacity building methods. A work plan was developed and continually reviewed. The purpose was clearly defined as providing a different approach to prevention and elimination of racial and ethnic health disparities in Berkeley. The CAT presented to the City Council twice, both times obtaining $200,000 annually for work on eliminating racial and ethnic disparities in health. Staff has been hired and is stabilized. Twenty resident advocates have been trained in community capacity building principles. This training was in social and economic determinants of health, community organizing, asset mapping, group facilitation, leadership, empowerment, and participatory action research.
The CAT is currently planning a Summit, called "Federal Government Challenges Us All to Eliminate Disparities in Health."

Lessons Learned:
Perseverance, faith and commitment are critical in establishing new programs. Communication is very important, but it must be broad and deep. All levels of staff in a city bureaucracy need to be a part of this communication. Power runs deep and each person along the way has a little bit of power to slow down a process. Ultimately, the wishes of the residents-based on their own experiences will carry the day.

Non-Invasive Urine Screening for STD in Adolescent

Cathy Johnson, RN
Child Health Program Coordinator
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Fax: (205) 930-1075
E-mail: cjohnson@jchd.org

Replicated: Yes
Evaluated: Yes

Essential MCH Functions:	**MCH Initiatives**
Adolescent school-linked/based services Communicable diseases Schools & health connections Building coalitions & partnerships	Assessment of provider reports regarding process and outcomes Special studies Development of models Support of health plans/provider networks Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Prior authorization for out-of-plan speciality services

Description

A Jefferson County Department of Health School-based Clinic participated in a surveillance study for STD in African American female adolescents during school year 2000. The study provided noninvasive LCR urine screening for chlamydia and gonorrhea for females presenting to the school-based clinic for services that did not indicate a need for STD testing. In order to test males, a limited number of LCR tests were donated by The University of Alabama in Birmingham's Infectious Disease Program. A set cohort of males was selected for urine screening. The varsity and junior varsity football teams at the high school were identified as the male screening group.

Objectives

The objective was to increase the identification of asymptomatic STDs in the target adolescent population. A total of 164 females who were asymptomatic and presenting for health services other than family planning were tested with the LCR urine screen. There were 24 positive tests resulting in a 15 percent positive rate. Breakdown of results: 58 percent positive for chlamydia; 42 percent positive for gonorrhea. LCR urine screens were performed on 68 male adolescents. The total number of positives was six with a 9 percent positive rate. All the positive tests were for chlamydia.

Barriers Encountered

1. Parental acceptance.
2. Acceptance from School Board.
3. Confidentiality for students.

Strategies to Overcome

The clinic has been in operation for eight years. Staff have established good lines of communication with the School Board, as well as with parents who value services provided and consider them to be both confidential and of the highest standards. Staff communicated with parents and school that the purpose for the surveillance study was a health issue, not a moral issue, and students were assured that all services rendered were strictly confidential. Consent forms signed by the parent and the student were obtained on all tested individuals. Only students who consented to be tested were asked for urine specimens. In addition, permission for male urine screening was obtained from the school principal and the school district superintendent. The testing on the females was done as a part of the clinic visit and only parental and student permission was necessary.

Funding Source: Other Federal
Description of other sources: Private Sources: UAB Infectious Disease\Abbott Laboratories
Budget: $322,000.00

Role of Health Department:
Jefferson County Department of Health (JCDH) partnered with the Univeristy of Alabama in Birmingham (UAB) Department of Adolescent Medicine to participate in the CDC surveillance study. JCDH obtained informed consent before testing and collected all data required, follow-up, educational counseling and treatment were all provided by JCDH.

Accomplishments:
-based on outcomes of screening, the JCDH has recognized the impact of direct and indirect cost savings of early intervention and treatment of sexually transmitted disease. The Board of Health has now allocated health departments funds to routinely perform LCR urine screening for STDs at Jess Lanier School-based Clinic (SBC).

Lessons Learned:
Non-invasive urine screening from STDs is an effective method to identify disease in the adolescent population. Early identification and early treatment can be easily provided in the school-based clinic environment. The noninvasive LCR urine testing for STDs allows for greater acceptance of STD testing especially in males and allows for natural dialogue between the school health staff and the adolescent concerning high-risk behaviors. The testing has allowed the SBC staff to identify STD infections early in a population that would most likely not be tested until symptomatic. Testing performed on a screening basis is noninvasive and is done in a routine nonjudgmental manner that allows the adolescent to present to clinic for some other "problem" and be screened. The adolescent does not have to initiate dialogue about concerns of exposure to an STD. Many students feel they never have to worry, but it is okay to be checked just to be sure. Students report high confidence in confidentiality of the SBC procedures. They are told what tests or procedures are performed each time, and staff are confident that the screening procedure will encourage students to access the clinic.

Increase Clinic Accessibility/4th DTaP Project

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Replicated: No
Evaluated: No

Essential MCH Functions:	MCH Initiatives
Immunizations Expanding private sector links Other outreach activities Building coalitions & partnerships	Hotlines, print materials, media campaigns Special studies Development of models Provide outreach services Provide, arrange, administer direct services Identify alternative resources to expand system capacity

Description

Central District Health Department proposes to provide increased access to immunization clinics by increasing the number of clinic hours (beyond usual and customary) in the four counties it serves. The department proposes to increase the number of fourth DTaPs administered by offering free immunizations to all children aged two years and under who receive immunizations at our clinics.

The department also proposes to increase the number of fourth DTaPs administered by reinstating a certification/reward program for childcare providers. The plan is to develop promotional aids, certificates, and appropriate gift certificate rewards as incentives to have children attending childcare centers up to date on immunizations. Childcare records will be examined by a nurse, recommendations made, and successful childcare providers recognized for their efforts in getting children up to date on their immunizations.

Central District Health Department proposes to utilize the following marketing avenues:

1. Radio spots on targeted stations using the Central District Health Department's jingle.
2. Newspapers in all four counties to include advertisements and public service briefs.
3. Poster/flier distribution through "Thumbtack Express."
4. Printed materials for public distribution and through child care centers.
5. Childcare provider incentive program.

The public advertising will include information about clinic hours and availability of no-cost immunizations for children up to age two years.

Objectives

Central District Health Department's objective is 90 percent immunization coverage for children at 24 months of age for each of the following: DTaP 4; Polio 3; MMR 1; Hib 3; Hep B 3 (4:3:1:3:3).

Barriers Encountered

1. Expanding the hours in the satellite offices
2. Changing the accounting procedures

Strategies to Overcome

Meetings were held to address the accounting changes and to educate staff.

Meetings with satellite office staff to identify the best way to accommodate clients beyond "usual and customary" hours.

Funding Source: Other Federal
Budget: $30,500.00

Role of Health Department:

The activity is a special project planned, implemented, and to be evaluated by Central District Health Department, as contracted with the Division of Health in Idaho's State Health and Welfare Division.

Accomplishments:
Two radio commercials about childhood immunizations have been planned, scheduled and/or run, a total of 394 times.
Childcare provider incentive money has been spent. *A grant request for incentive dollars is pending.*
Free recommended immunizations for children before their second birthday care being provided.
Some newspaper ads have been run.
Materials have been printed.
Extended hours are available in the main office and satellite offices

Lessons Learned:
The cash/gift certificate incentive for childcare providers is a big success.

breast-feeding Challenge Grant

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Replicated: No
Evaluated: No

Essential MCH Functions:	MCH Initiatives
Breastfeeding/nutrition/WIC Staff training	Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Staff training

Description

The goal of this project was to evaluate the impact of how the use of low literacy/ethnically sensitive videos and handouts and the integration of public health programs would impact breast-feeding rates. The WIC participants were educated on the benefits of breast-feeding at the initial WIC contact, and received additional support at the WIC certification of the infant and the postpartum women, and during home visits to the breast-feeding women performed by Healthy Start (HS) staff.

Objectives

1. The percent of project infants who are initially breastfed will increase from 16.76 percent to 18.76 percent by June 30, 2001.
2. The percent of project infants who are initially breast-fed and continue to breastfeed past one month will increase from 54.1 percent to 56.1 percent.
3. The percent of project infants who are breast-feeding at 5-6 months will increase from 10.7 percent to 12.7 percent.

Barriers Encountered

The program faced challenges in selecting supportive male representative with the ethnic and cultural backgrounds of the WIC population for the breast-feeding video; in arranging times and locations for the photo shoots and taping of the audio visuals especially for the men who had to miss work or adjust their working schedules; and in scheduling time for educating the staff on breast-feeding.

Strategies to Overcome

The training of the HS and WIC staff was conducted in two sessions. Volunteers for the video/posters and handouts included WIC clientele and Chicago Department of Public Health (CDPH) staff whose infants were breastfed, and selected college students. The male volunteers were able to adjust their work schedules. The staff from the Chicago network, "City Works," located a venue for the video taping.

Funding Source: Other Federal
Description of other sources: WIC funds
Budget: $10,000.00

Role of Health Department:

The health department identified the community area most in need of improvement in breast-feeding rates and what methods should be used to accomplish these objectives. CDPH used existing WIC data on breast-feeding to select the Englewood Community area for the project. The breast-feeding rates were among the lowest in the city. The WIC program also determined that male involvement and support of breast-feeding would have a positive effect on the breast-feeding rates among the African American population.

Accomplishments:

Through counseling, follow-ups, and home visits, the initiation rates increased from 16.76 percent to 21.1 percent, and the cessation rates of breast-feeding increased from 54.1 percent to 58.1 percent. Low literacy and ethnically sensitive handouts and posters were finally completed in June 2001 for the African American and Latino/Hispanic clients. These handouts and posters were geared to stimulate the interest of breast-feeding in pregnant women and highlight the benefits of breast-feeding for the mother and child. The handouts and posters portrayed the infant talking to the mother and explained how breast feeding is good for both the mother and child. We produced a video entitled, "breast-feeding: Good for The Whole Family," to highlight the role of the male partner in successful breast-feeding. The video has been aired on "Chicago Works," the City of Chicago Cable Network at least twice. The videos, posters, and handouts will be used at all WIC sites and public health facilities to promote breast-feeding in the next year.

Lessons Learned:

1. Men are happy to be supportive of breast-feeding if their assistance is solicited.
2. Realistic deadlines in developing audio visual materials must be established.
3. Staff who implement the program must be carefully educated and monitored.

Pregnancy Testing and Counseling

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Replicated: Don't Know
Evaluated: Don't Know

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Essential MCH Functions:	**MCH Initiatives**
Family planning Prenatal care Home visiting Low birthweight/infant mortality Teen pregnancy One-stop shopping locations Other outreach activities	Provide outreach services Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services

Description

Over three thousand pregnancy tests are performed yearly at El Paso County Department of Health and Environment. Pregnancy tests have been offered free of charge at our agency on a walk-in basis. Women could obtain a test, get the results and leave. We contacted other community agencies offering free or low cost pregnancy tests to determine whether "post test" counseling services were offered to clients. Counseling services were offered at the various agencies on a sporadic basis. After initiating a client survey as to who obtains tests and why at our health department, we found many teens and young women repeatedly coming to get a test. Many of the women were not using any type of birth control. Reasons were varied.

We felt that by having a public health nurse available for counseling we would reach clients at a "teachable moment" for family planning services or prenatal services. We would offer "delayed exams" where birth control pills could be dispensed on the spot instead of waiting for a three to four week family planning appointment. We would offer one-stop services for pregnant clients to access care and resources. In January 2000, we began a pilot program to provide a public health nurse to meet with each individual requesting a pregnancy test from 12:30-4:30 pm, Monday through Friday. We would determine whether the test was timely, and then review options-based on the results and offer birth control and/or refer to community agencies as appropriate.

Our goal was to impact the unintended pregnancy rate in our community, provide early access to care and offer one-stop services through our agency. Due to the success and request for services, pregnancy testing and counseling is now available full-time.

Objectives

1. Determine the appropriateness of the pregnancy test and do health teaching
2. Provide early access to prenatal care for clients with positive tests
3. Provide preconceptual counseling for those trying to get pregnant
4. Provide early access to family planning services for those with negative tests
5. Refer for additional needed services (WIC, DHS, Medicaid, CHP+EPSDT, STD services, etc.)

Barriers Encountered

This program impacted all departments in our agency. Communication and cooperation between the various departments was time-consuming and sensitive. Public health nurses who have been distancing their practice from "direct services" were hesitant to prescribe birth control, even under the signature and approval of the medical director.

Strategies to Overcome

Open dialogue and frequent meetings to discuss the issues helped overcome the barriers. We continue the dialogue to address new ideas and issues.

Funding Source: State
Budget: $90,762.00

Role of Health Department:
Although community collaboration has been the focus of many of our strategies, this program was designed internally to enhance one-stop shopping for clients utilizing the health department. After the pregnancy test is done, the client has access to WIC, EPSDT, STD clinic, Medicaid applications, Child Health Plan Plus applications, Prenatal Plus case management services, Parent/Nurturing Program, Prenatal/Clinic, Family Planning Clinic, and Drug and Alcohol Programs, as well as referrals to other community agencies.

Accomplishments:
1. By reviewing the menses cycle and the lasts menses date, we were able to delay pregnancy tests that were too early to be accurate. These women were counseled on using birth control methods, monthly cycles, and time when conception can occur, as well as explanations of when tests should be performed.
2. Some of the women were on birth control but were having spotting, missed a day or two of pills, or had general concerns. We had not anticipated this opportunity to educate those already utilizing family planning services but had questions and possibly were noncompliant because of these concerns.
3. We referred women with positive pregnancy tests to prenatal care, either with our clinic, another community low cost clinic or with a private physician. We stressed the importance of early prenatal care. Information was given about the importance of healthy lifestyles during the pregnancy. Those who were trying to become pregnant were given information about the importance of folic acid and smoking cessation. Presumptive eligibility cards were issued, appointments made at WIC and with our clinic for those interested in using our prenatal services.

Lessons Learned:
All of the services offered through this program were already available at our agency. By coordinating these services with the help of a nurse to explain the various programs, we are giving more options and better accessibility to the clients using our agency. It is a wonderful teaching opportunity as well.

Immunization Tracking Program

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Replicated: No
Evaluated: Yes

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Essential MCH Functions:	**MCH Initiatives**
Immunizations	Tracking systems

Description
Immunization Tracking Program for Richland County.

Objectives
Agency's Strategic Plan objective was "to maintain at 90 percent and/or increase the percent of children appropriately immunized for age."

Barriers Encountered
1. Being received in private providers offices to overcome low immunization rates by checking patients' records for immunization data.
2. Creating system to overcome problem of tracking more than 1,000 children that become delinquent on a monthly basis.

Strategies to Overcome
1. Established excellent working relationship with private medical practices that allowed entrance into their practices to search their files for the missing immunization information.
2. Working AIMS Delinquent List weekly, instead of monthly; reaching out to families by telephone and by mail.
3. Maintaining manual tracking system to track delinquent children using ITC cards.

Funding Source: General state funds, Third party reimbursement
Budget: $95,000.00

Role of Health Department:
Our role is to protect children, adolescents and adults from vaccine-preventable diseases through immunization. We have provided primary leadership in data collection to help facilitate non-DHEC providers, who do not have established reminder/recall.

Accomplishments:
Drastic improvement in Delinquent Immunization Rate for Richland County; from 77 percent as of 4/1/99 to current rate of 96 percent.

Lessons Learned:
Systematic obstacles have been overcome by developing personal rapport with non-DHEC.

Somali Women's Talking Circles

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Replicated: Don't Know
Evaluated: No

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Essential MCH Functions:	**MCH Initiatives**
Prenatal care Immunizations Overcoming cultural barriers	Community perceptions of health problems/needs Culturally appropriate health education materials/programs

Description

Columbus has become dramatically and more richly racially and ethnically diverse over the last five years. We have seen increases in our African American, Asian/Pacific Islander, Hispanic and American Indian residents, along with emerging new immigrant and refugee populations. This activity focused on obtaining from and providing to Somali women, information to help improve their experience with health systems and improve maternal and child health status.

Four "Somali Women's Talking Circles" were held in three locations throughout Columbus with a total of forty participants. Each session was two hours in duration. The "Talking Circles" were conducted by a Registered Nurse with MCH experience in collaboration with a local Somali community-based organization. The role of the Somali organization was to provide community outreach for participants, arrange the location and provide language interpretation and translation of educational materials. Topics discussed included: benefits of prenatal care and importance of early prenatal care, available resources, typical prenatal schedule and assessments done, vaginal/c-section delivery, postpartum visit, contraception, breast feeding/bottle feeding, Back to Sleep, well childcare visits, immunizations, and infant/child safety seats. The women were very participatory in discussions concerning differences in cultural norms and religious beliefs as they related to health and by asking questions concerning the health information presented.

Objectives

1. To obtain the views and concerns of Somali women in Columbus regarding cultural differences and similarities in maternal and child health practices and care.
2. To increase awareness and provide education concerning maternal and child health issues.

The ultimate goal was: Retention of healthy customs and adoption of new health behaviors that can increase opportunity for healthier mothers and children.

Barriers Encountered

1. Language: Although interpreters were available, the process over a two-hour period became cumbersome. When a male interpreter interpreted one session, the nurse coordinator felt that the women were not as participatory in the presence of a man.
2. Gathering of Somali women for participation: The "Talking Circles" were implemented with women already coming together for ESL classes, which somewhat limited the timing of the "Talking Circles." This challenge also limited the number of "Talking Circles" to four instead of the planned six to eight sessions.

Strategies to Overcome

1. Language: The use of an interpreter is essential. If additional "Talking Circles" are conducted we will meet with the interpreters to discuss how to best utilize their services and we would require a female interpreter for every session.
2. Gathering of Somali women: Subsequent to our beginning the project, a community-based organization comprised of Somali women had been established. If we conduct additional "Talking Circles" we will request their assistance in this project also.

Funding Source: Private Source
Description of other sources: March of Dimes, Central Ohio Division
Budget: $1,500.00

Role of Health Department:
Staff from the Office of Minority Health envisioned this project, secured funding and provided oversight for the initiative.

Accomplishments:
1. A better understanding of the views and concerns around MCH issues for Somali women in Columbus.
2. The project provided a vehicle for interactive educational sessions concerning MCH issues giving an opportunity to enhance the health status and health systems experience of Somali women and children.
3. Strengthen relationships with our Somali community.

Lessons Learned:
1. Many of the women were willing to seek prenatal care but desired female physicians.
2. Many of the women understood and were accepting of the importance of well-child care and childhood immunizations.
3. Language barrier was the number one challenge identified in accessing health care, followed by lack of transportation and lack of medical insurance and knowledge of low cost medical care.

Healthy Youth/Healthy Adults

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Replicated: No
Evaluated: No

Essential MCH Functions:	MCH Initiatives
Schools & health connections Building MCH data capacity	Community perceptions of health problems/needs Population surveys (BRFS. PRAMS, PedNSS, YRBS) Special studies Newsletters, convening focus groups, advisory committees, networks Staff training Support of continuing education Support of health plans/provider networks

Description

The objective of the Healthy Youth/Healthy Adults grant, is to develop baseline data on the risk behaviors of the teenage population of Nueces County, as well as to track and assess the prevalence of adolescent obesity.

Objectives

Survey 1500 ninth and tenth graders in Nueces County in a modified version of the CDC YRBS.
Collect dietary information from 500 of the 1,500 students in the study.
Obtain physical activity data from 50 students through the use of activity monitors.

Barriers Encountered

The county bureaucratic processes in contract negotiation and purchasing have considerable time delays.
The TAAS Test and school district timeliness for preparing for the test have also handicapped the implementation.

Strategies to Overcome

The barriers with the county are being overcome with patience and making up time by modification of the data collection procedures.
The barrier imposed by the TAAS Test is being overcome by maintaining flexibility with the school districts in order to take advantage of opportunities as they arise.

Funding Source: Other
Description of other sources: Innovation grant funding from State's awarded tobacco monies interest.
Budget: $0.00

Role of Health Department:

Corpus Christi-Nueces County Public Health District along with the principal investigator from the University of Minnesota School of Public Health planned the initial phases of the program. The majority of the implementation of the program was done by Corpus Christi-Nueces County Public Health District, by initiating meetings with surrounding school districts and community agencies.

Accomplishments:

Healthy Youth/Healthy Adult has successfully surveyed 1,800 students.
Healthy Youth/Healthy Adult has successfully collected dietary information from 350 students.
Healthy Youth/Healthy Adult has obtained physical activity data from 50 students.

Lessons Learned:

Patience and flexibility are the keys when working with rigid systems.

Motheread

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Replicated: Yes
Evaluated: Yes

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Essential MCH Functions:	MCH Initiatives
School-linked/based services Adolescent school-linked/based services Teen parenting Schools & health connections Other outreach activities Building coalitions & partnerships	Culturally appropriate health education materials/programs Prepare, publish & distribute reports Public advocacy for legislation & resources Provide outreach services

Description

Motheread/Fatheread (copyright) is a nationally recognized and proven program, that uses children's books to provide context sensitive parenting and problem solving skills for parents, child educators, and providers. It uses simple nonthreatening methods, and provides insight into how children think and behave and how best to respond to them. Motheread encourages family literacy while enhancing the family's problem solving skills.

Objectives

To help the parents learn new means of thinking and doing in order to empower them to take more responsibility for their child's welfare.

Barriers Encountered

Language - Only a small number of classes target Spanish speaking families because staff are not bilingual. There is also a lack of availability of appropriate culturally sensitive children's books in various languages.

Strategies to Overcome

The department plans to train Spanish speaking city staff and partners in Motheread. Doubling the number of Motheread trained staff will double the population reached. Large national suppliers of children's books were contacted and made aware of the types of books needed. Our health centers sponsored book drives to collect multi-lingual books.

Funding Source: Local Government
Budget: $3,000.00

Role of Health Department:

1. Staff training.
2. Identify schools and making contacts in order to partner.
3. Train staff from other agencies in an attempt to expand services.

Accomplishments:

1. Partnering with local ISD to increase reading skills.
2. Parental participation encouraged.
3. Encouraging parents who are illiterate to learn to read so they might better interact with their children.

Lessons Learned:

1. The need for ongoing and continuous training of staff for Motheread.
2. The limited availability of approved bilingual children's books.

Community Child Health Centers Media Campaign

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Replicated: Don't Know
Evaluated: Yes

Essential MCH Functions:	MCH Initiatives
Overcoming cultural barriers Expanding private sector links Clergy & health connections Other outreach activities Increasing social support Strategic planning Building coalitions & partnerships	Hotlines, print materials, media campaigns Provide infrastructure/capacity for MCH functions Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them

Description

The Marketing Campaign of Community Child Health Centers- accomplished by:
1. Television and radio ads a) increased awareness of services to community; b) created access by allowing appointments to be made by calling in at time of ad.
2. Direct canvassing of WIC and prenatal populations.
3. Direct phone calling to families who indicated health services need on multi-agency referral form.
4. Presentation and brochure distribution to over 120 agencies, schools, medical groups, and community organizations.
5. Distribution of brochures and reinforcing packets to 13 local food pantries.
6. Present and future outreach promotions to prenatal and community-based population in the form of brochures/reinforcing packets.
7. Mailing to over 700 businesses defined as having employees lacking in adequate health care insurance coverage.
8. Mailing of brochures and reinforcers to approximately 200 agencies, schools, medical facilities and community organizations who had been contacted via presentation or promotional activity in the campaign. This mailing to take place in the summer, three to four months after initial contact as reminder of health care services.

Objectives

1. Increase of new appointments (both kept and "no shows").
2. Additional requests for brochures from community agencies, schools, business, etc.

Barriers Encountered

1. Collaboration to serve through referrals to other agencies so that health care needs are met.
2. Internal structures which inhibit health care services from being delivered.
3. High rate of missed appointments.

Strategies to Overcome

1. Collaborative group efforts are compiled in order to achieve unduplicated services for families.
2. Agency is attempting to meet the needs of families by offering extended hours, need assessments, referrals for other services, and assistance in the Medicaid eligibility process.
3. Double booking appointments on high rate "no show" days is maintaining a steady workload balance.

Funding Source: Local Government
Budget: $973,365.00

Role of Health Department:
The role of the health department has been planning and implementing the media campaign, under the advisement of a marketing consultant firm.

Accomplishments:
Increased awareness of Community Child Health Centers within the community. Awareness levels have risen in both populations in need of services and agencies/organizations who refer families for health care. An increase of new appointments and collateral contacts with agencies/organizations for information and brochures have show an increase of awareness.

Lessons Learned:
1. Promotion of services needs to be ongoing.
2. Population in need of services is continuously changing.
3. Families who are not receiving other services (i.e., WIC, Prenatal) were those who were most unaware of child health services.

WIC-Lead Testing Connection

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Replicated: Yes
Evaluated: No

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Essential MCH Functions:

- Breastfeeding/nutrition/WIC
- Early intervention/zero to three
- EPSDT/screening
- Lead poisoning
- Other outreach activities
- Increasing access to Medicaid
- Staff training
- Reshaping urban MCH
- Building coalitions & partnerships

MCH Initiatives

- Community perceptions of health problems/needs
- Implement/support education services for special MCH problems
- Staff training
- Labortory capacity
- Provide outreach services
- Monitor enrollment practices for ease of use
- Identify high-risk/hard-to-reach populations & methods to serve them
- Provide, arrange, administer direct services
- Identify alternative resources to expand system capacity

Description

Lead poisoning is the number one environmental hazard for Detroit's children. It is estimated that over 12,000 children under the age of six currently suffer from the many devastating effects of lead poisoning. In 1999, of the 25,865 children who were tested 3,739 (14.5 percent) had an elevated lead level (10ug/dL or higher).-based on 1997 population estimates, of 109,594 children under the age of six, 76 percent of the children have not been tested for lead poisoning. The importance of testing is underscored by old and deteriorating housing stock, built before 1950, making it a prime source of lead paint. These homes are often inhabited by the 42 percent of Detroit's children who live in poverty and their families. Poverty often leads to deteriorating properties, poor nutrition, and other barriers to good health. These factors add up to neighborhoods where lead poisoning presents a clear and present danger to Detroit's children. Testing children for lead is a proven method of identifying poisoned children, yet the number of children tested has declined in Detroit. This activity describes one intervention to increase childhood lead testing in Detroit.

Objectives

1. By December 31, 2001 increase the percentage of Detroit's children under the age of six, tested for lead from 22 percent to 30 percent of the population.
2. By December 31, 2001 increase the percentage of Detroit's children one to two years of age, tested for lead from 24 percent to 50 percent of the population.
3. By October 1, 2001 through data review and analysis, determine the lead testing rates for Detroit's Medicaid children under six (citywide and those receiving WIC services).
4. By December 31, 2001, 4,000 WIC participants will receive lead testing and nutrition education through the WIC-Lead Testing Connection with sites increased from six to eight by December 31, 2001.

Barriers Encountered

1. Selecting WIC sites for testing.
2. Determining staff/resources for testing the children in WIC (WIC staff, Lab staff, EPSTD, staff, or others).
3. Training WIC staff to test.
4. Scheduling staff to test in WIC at peak times coordinated with certification/recertification of participants.
5. Returning blood lead specimens to the lab before the lab closes in the evening and on weekends.
6. Staff agreement on the importance of testing WIC children for lead.
7. Resolving labor relations and union issues regarding work assignments.

Strategies to Overcome

1. Administrative support required to shift resources and make lead testing a priority for the department.
2. Coordinated lead testing training with lab director for Community Health Assistants.
3. Reassign staff to WIC sites with no lab on-site, and coordinated staff's schedules with WIC schedule.

4. Hold regular meetings with Medicaid outreach supervisor, WIC supervisor, and Lead Program director to discuss barriers and solutions.
5. Continue evaluation and analysis of lead poisoning prevalence and number of tests conducted by each site to assess testing need at sites and identify other WIC testing locations.
6. Inform the unions and department internal task force on the importance of testing children for lead.

Funding Source: MCH block grant
Budget: $75,000.00

Role of Health Department:
Childhood lead poisoning in Detroit has become a top priority for the Detroit Health Department. A Childhood Lead Poisoning Prevention Initiative began with the Public Health Director signing a public health policy calling for the universal testing of all children under the age of six years living in the city. This policy was communicated through the media at a press conference, and with an outreach campaign of billboards, bus boards, and mass mailings of the testing policy to hundreds of medical providers. The department decided to address its internal lead testing activities by connecting four health department programs (Medicaid Outreach, WIC, Childhood Lead Poisoning Prevention and Control Program, and Public Health Nursing Services); thus began the WIC-Lead Testing Connection.

Accomplishments:
1. Implemented testing of WIC children (five years of age and younger) for blood lead poisoning in December 2000.
2. Testing over 300 children each month with calendar year 2001 total of 2,507 children tested.
3. Testing at six WIC sites (two at state social services offices and four at primary care centers) and planning to expand to other locations.
4. Overall city testing rate of children six years and under has increased by 13 percent and lead testing rates citywide for one-two years olds increased from 29 percent to 38 percent. Lead testing outreach, marketing, and this initiative have contributed to the success.

Lessons Learned:
1. The WIC program sites are excellent locations to conduct lead testing and provide lead poisoning prevention education.
2. Testing WIC participants is an effective method to increase testing of at-risk children in Detroit.
3. Quality assurance must be emphasized for lead testing, and staff must receive appropriate training as necessary to adhere to the proper technique for capillary testing.
4. The need to stress hand washing before the test and provide soap, water, and paper towels at sites to ensure accurate results.
5. Establishing a city-wide universal lead testing policy is an important first step in educating providers to test children, and assuring that the health department programs coordinate efforts to test children.

Together Everyone Accomplishes Something

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Replicated: No
Evaluated: Yes

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Essential MCH Functions:

- Family planning
- Substance abuse prevention
- Adolescent school-linked/based services
- Violence prevention/at risk
- Teen pregnancy
- Communicable diseases
- Family violence
- Dental programs
- Schools & health connections
- Other outreach activities
- Increasing social support
- Building coalitions & partnerships

MCH Initiatives

- Tracking systems
- Hotlines, print materials, media campaigns
- Culturally appropriate health education materials/programs
- Development of models
- Newsletters, convening focus groups, advisory committees, networks
- Support of continuing education
- Provide outreach services
- Transportation & oter access-enabling services

Description

Together Everyone Accomplishes Something (TEAS), established in 1998, is a five-year pregnancy prevention program. Each year, 15-20 male and female teenagers and their parents, guardians, or mentors are accepted into the program. Once accepted, the teenagers and their mentor sign a contract to participate. The contract states that they will communicate honestly and openly to delay the initiation of sexual activity, to use contraception if they are sexually active, to remain in school, and to abstain from drug use. Teenagers and their mentor receive life skills education and participate in a variety of group and recreational learning activities. These activities are designed to expose them to different life experiences. In addition, each participant is required to keep "Baby Think It Over" (an infant simulator) or wear the "Empathy Belly" (a pregnancy simulator); for a designated period of time, they are also expected to participate in a community service project. After successfully completing one program year, teenagers are promoted to an advanced level in the program. Some of the responsibilities at the advanced level include being responsible for recruitment of new participants, mentoring, group facilitation, event planning (for Teen Pregnancy Prevention Month), and peer education. Adult mentors are requested to participate in quarterly advisory meetings.

Objectives

The overall goal of TEAS is to reduce teenage pregnancy in Durham County by achieving the following objectives:
1. To delay the initiation of sexual activity among all program participants.
2. To promote contraceptive use among program participants that are sexually active by 100 percent.
3. To keep all participants enrolled in school and satisfactorily completing course by securing at minimum, a passing grade.
4. To prevent drug use among program participants.

Barriers Encountered

Major implementation barriers include:
1. Dispelling the myth that only low-income minority families are at risk for teenage pregnancy and school dropouts.
2. Lack of racial diversity among participants, as currently a large majority of participants are African-Americans. Although, efforts have been made to include other ethnic groups, the results are somewhat disappointing.
3. Parental denials that their teenagers are sexually active, and therefore, they are reluctant to enroll them into TEAS.
4. Teens' perceptions that TEAS is an "abstinence only" program.

Strategies to Overcome

Although barriers are not totally overcome, substantial improvements have been made through the use of extensive program marketing and mass media advertising. Current TEAS participants are fully engaged in recruiting new participants and developing TV commercials. These efforts have enabled teenagers to view themselves, not only as part of the problem but also as part of the solution as well.

Funding Source: Other Federal
Description of other sources: TANF
Budget: $25,000.00

Role of Health Department:

1. Additional funding.
2. Staff time to coordinate program activities.
3. Resources from departmental division (i.e., clinical services such as family planning, immunizations, etc.).
4. Meeting facilities.
5. Evaluation.

Accomplishments:

Out of the original 15 teenagers who were enrolled at the initiation of the project, 14 are currently in their fourth year of the project. There are nine boys and 38 girls enrolled in TEAS. Our record shows that none of the teenagers became pregnant or caused pregnancy since their enrollment in TEAS. All enrollees have successfully achieved passing grades and therefore, have not failed or repeated courses or classes. TEAS has purchased computer software for English, Math, Language Arts, and PSAT/SAT to assist participants. Additionally, tutoring and study groups are provided as needed.

Although parent mentors are required to participate fully only in the first two of their child's program years, many third and fourth year parents continue to participate in the program. Currently there are 36 parents/guardians who serve as mentors and provide transportation for other TEAS activities. TEAS also provides comprehensive referrals and assistance for domestic violence, death and dying, job placement, etc. TEAS participants have also secured donations of food and clothing to assist the needy.

Lessons Learned:

1. Effective parent and child communication is a very important tool for behavior modification/change.
2. Many parents inherently possess the skills to become good teachers and mentors. What they need is support, encouragement, and guidance.
3. The majority of the teenagers are not sexually active, and those who are need guidance to access reproductive health care services.

Perinatal Initiative

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Replicated: Don't Know
Evaluated: No

Essential MCH Functions:	MCH Initiatives
Low birthweight/infant mortality	Community perceptions of health problems/needs
Expanding private sector links	Implement/support education services for special MCH problems
Other outreach activities	Provide outreach services
Case coordination	Referral systems, resource directories, advertising, enrollment assistance
Building coalitions & partnerships	

Description
Data collected by the local FIMR (Fetal Infant Mortality Review) Committee in the past two years indicate that the majority of infant and fetal deaths in our community have occurred in situations where a private physician has provided prenatal care, rather than through one of the clinics that targets low income, high-risk pregnant women. Most of these women had private insurance and were being followed by a private physician practice. In an effort to improve perinatal outcomes a new outreach program was developed by the Regional Perinatal Advisory Board (RPAB) and the Vanderburgh County Health Department Public Health Nurses (PHNs). The goal was to form partnerships with physicians and their clients to improve pregnancy outcomes and reduce the infant mortality rate in Vanderburgh County. One PHN acted as the liaison to each physician practice including urgent care centers and emergency rooms. The PHN was responsible for introducing the initiative to the staff and physician in each office, update the office regarding FIMR and RPAB findings, provide offices with free educational materials to give to their prenatal clients, and serve as contact person for referrals. As an incentive, the meetings were scheduled for either a breakfast or lunch meeting and food was provided to staff.

Objectives
1. Increase physician awareness of FIMR findings and community resources that would serve the needs of the client population.
2. Increase provision of educational materials to pregnant women served by private physicians.
3. Increase referrals for prenatal care coordination and pre- and postnatal home visits.
4. Increase and enhance continuity of care and increase communication between PHNs, physicians, office staff, and clients.

Barriers Encountered
1. Limited staff time: The PHNs were responsible for contacting the private physicians and scheduling either a breakfast or luncheon meeting with the physician and office staff to discuss the outreach efforts. In addition, the nurses continued with their routine home visits and referrals within their individual caseloads of clients.
2. Short time frame to utilize funding obtained (June-Sept. 2001). Due to our county's active and progressive FIMR committee and no IPN consultant to replace the one who had resigned, the Indiana Perinatal Network (IPN) granted $8,000.00 to Southern Indiana to be utilized to address infant mortality and disparity issues. The money was awarded in June, 2001 with the stipulation that it had to be spent by September 30, 2001. Since this will be an ongoing project, we will be unable to provide food at the in-services after September. The remaining money will be used to purchase literature and supplies to be used throughout the next year.
3. Poor reception from several private physicians and/or staff. Many physicians have stated that their patients are receiving adequate information about having a healthy pregnancy.

Strategies to Overcome
1. Other health department staff were utilized to assist in making copies and putting together informational packets. One Girl Scout troop and a center for juvenile delinquents were also used to assemble packets.
2. Additional funding was requested and received through the health department's budget for Fiscal Year 2002.

3. We will continue to make contacts to physicians and to supply them with the prenatal handouts that we have. We have learned that the best way to make their initial contact is through the office manager or nurse in the office instead of the physician. Several nurses have requested our literature and information.

Funding Source:
Description of other sources: Indiana Perinatal Network
Budget: $8,000.00

Role of Health Department:
As a "neutral agency" and the sponsoring agency of FIMR, the health department assumed the responsibility for this initiative. We have several PHNs certified to provide prenatal care coordination and to make home visits to pregnant women. They are familiar with other resources for pregnant women in our community and collaborate with staff of other prenatal clinics in the community. The health department has also been responsible for ordering supplies and brochures.

Accomplishments:
One of the major accomplishments has been the communication between private offices and health department staff. Many physicians didn't realize that they could make referrals to the PHNs with no charge to their patient. There has been an increased awareness of infant mortality issues in our county due to local newspaper coverage. The physicians and their staff have increased awareness and understanding of the Prenatal Care Coordination Program through Medicaid.

Lessons Learned:
We have learned that bringing together the public and private community together can be quite challenging. Several physicians are unwilling to discuss partnerships with the health department (possibly due to feeling threatened). One of the lessons learned is that many physicians are not educating their patients on some of the most important prenatal issues such as signs of preterm labor, good nutrition while pregnant, Back-To-Sleep, smoking and exposure to secondhand smoke, etc. Through this initiative we have also learned that we need to advertise our existence and services to the community to ensure that all residents have a source of health information if they don't receive it from their physician.

"To Make People Safe" Strategic Plan

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Replicated: Yes
Evaluated: No

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Essential MCH Functions:	**MCH Initiatives**
Injury (including child abuse)	Community perceptions of health problems/needs
Violence prevention/at risk	Population surveys (BRFS. PRAMS, PedNSS, YRBS)
Family violence	Prepare, publish & distribute reports
Overcoming cultural barriers	Public advocacy for legislation & resources
Expanding private sector links	Develop & promote MCH agenda and YR2010 National Objectives
Other outreach activities	Newsletters, convening focus groups, advisory committees, networks
Increasing social support	Promote compatible, integrated services system initiatives
Staff training	Consistent, coordinated policies across programs
Strategic planning	MCH input in legislative base for health plans & standards
Building coalitions & partnerships	Detention settings, foster care, mental health facilities
	Profiles of provider attitudes, knowledge & practices

Description

The strategic planning process intended to further strengthen the integration of services around the prevention, intervention, treatment and elimination of family/domestic abuse and violence in Fresno County. It focused on collaboration of individuals and coordination of integrated services for Fresno residents served by the four departments of the Fresno County Human Services System and among the major stakeholders within the Community Services System.

During November-December 1999, nearly 200 staff representing all four departments and administration of the Human Service System met in a series of discussion groups. During February and March 2000, representatives of the Community Services System in Fresno County met in a series of discussion groups. The participants included the Fresno County Human Services System, judiciary, law enforcement, and probation representatives, nonprofit providers such as the Marjaree Mason Center, and many others. The participants, representing various segments of both systems, identified the strengths of the existing system, the limitations and challenges faced by the system, and potential solutions to build upon the strengths and overcome the limitations and obstacles.

The response by the participants cluster into three basic focus areas, which are defined in THE PLAN.

Objectives

Develop and publish THE PLAN to the Board of Supervisors and community, to be used as a working document and a tool to strengthen and improve the Human Services System as they intersect and interact with the Community Services System.

Barriers Encountered

"To Make People Safe."

To review the system-wide planning process, identifying within our own organizations and programs where each has responsibility for implementation of activities outlined in THE PLAN.

To replicate the process of the planning team in each department within the Human Services System and the departments and agencies in the Community Services System; identifying the strengths and gaps, developing an individual "organizational plan" which complements and enhances THE PLAN.

To set aside individual interests for the good of community, thus continuing to strengthen the system, "To Make People Safe."

Strategies to Overcome

Presentation to Board of Supervisors by Presiding Judge of Superior Court in September 2001.

THE PLAN is publicly supported by the Fresno County Domestic Violence Roundtable, convened by the Justice of State Fifth District Court of Appeals.

Publication and distribution of 750 copies to stakeholders throughout the community.

Press release regarding document.

Funding Source: Local Government
Description of other sources: General state funds, MCH Block grant funds
Budget: $75,000.00

Role of Health Department:
Presented the need for a strategic plan in an education session before the Board of Supervisors in May 1999.
Engaged policy makers to support the activity of strategic planning.
Wrote the grant proposal to support the activity of strategic planning on behalf of the local Domestic Violence Roundtable (of which we are a member).
Facilitated the scope of work.
Sub-contracted for the meeting/planning facilitator.
Providing technical assistance and consultation to the process.

Accomplishments:
Document published.
Many recommendations already implemented.
Partnerships and collaborations initiated and strengthened.
New ideas coming forward for collaboration.
Opportunity for increased communication.

Lessons Learned:
Facilitating collaboration across highly structured organizations and systems is very challenging. It takes skill, patience and much more time than anticipated.

Edgewater WIC/Immunization Linking Project

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Replicated: Don't Know
Evaluated: Yes

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Essential MCH Functions:	MCH Initiatives
Immunizations	Identify high-risk/hard-to-reach populations & methods to serve them

Description

This project explored factors that influence parents' success in bringing immunization records to a WIC visit, and the relationship between WIC client characteristics and the likelihood of being up-to-date for immunizations. Interview surveys were conducted with parents of all WIC clients between birth and 35 months of age over a four month period. Parents received a 24-hour advance reminder call to bring immunization records to WIC visit. Survey results found:

1. Parents of children who received reminder calls believed their child was up-to-date.
2. Parents who used public rather than private providers were more likely to bring records to the visit.
3. Only 32 percent of the sample were up-to-date with immunizations.
4. Almost 70 percent of parents with children who were not up-to-date reported no difficulties obtaining immunizations.
5. Barriers to getting immunizations were transportation, cost and parents' work schedules.
6. Highest immunization rates were in children aged 19 to 35 months, with one or less siblings, on Medicaid, with public sector provider and having a history of low birthweight.
7. Interventions to improve the rate of parents who bring records to WIC visits and to improve immunization rates were implemented.

Objectives

1. To assess factors that affect immunization rates and success of bringing immunization records in a four month sample of WIC clients ages birth through 35 months.
2. To implement at least three interventions-based on assessment results with a goal to improve rates of parents bringing records and rates of immunization in that population.
3. To share project methods and outcomes at the local, state and national levels.

Barriers Encountered

1. Unpredictability of ongoing funding.
2. Inconsistency of staff resources to make reminder phone calls to bring records to visits.
3. Lack of understanding or recall of parents as to when immunizations are due.
4. Lack of understanding or recall of parents to keep records easily retrievable.
5. Lack of understanding or motivation of parents to fully use health care benefits.

Strategies to Overcome

1. Immunization staff is entering immunization record data for WIC clients as records are conveyed by WIC staff.
2. Immunization staff is performing reminder and recall for immunizations due and delayed on a monthly basis from immunization database.
3. WIC staff is making reminder calls to bring records to WIC appointments as staff time allows.
4. EPSDT outreach coordinator assists families in accessing child health insurance, if needed, and explains how to use benefits.

Funding Source: Other Federal
Budget: $34,600.00

Role of Health Department:
The role of the Jefferson County Department of Health and Environment (JCDHE) has been to take the lead in forming a partnership with the Colorado Department of Public Health and Environment and the JCDHE WIC program staff, as well as the JCDHE epidemiologist to design, implement, and evaluate a project focused on improving the rate of parents bringing immunization records in a targeted population, and share outcomes with the community.

Accomplishments:
-based on the poor immunization rates, a monthly immunization clinic was started at the Edgewater WIC site. A feedback loop has been created between the immunization and WIC programs to track and target children delayed in immunization. This is improving the rate of immunization records brought to WIC visits. The project will be presented at the Colorado Public Health Association and the American Public Health Association 2001 annual meetings. In addition, an article has been submitted to a national journal for publication.

Lessons Learned:
Reminder and recall activities may be more effective than some incentives for returning to clinic for immunizations. Parents may still prefer the convenience and lower cost of using public immunization clinics rather than using their own provider for immunizations. With limited resources and without a statewide immunization registry, it may be more feasible to build strong links between immunization program staff and WIC program staff to assure assessment and referral of children for immunization.

Continuity of Care in breast-feeding

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Replicated: Yes
Evaluated: Yes

Essential MCH Functions:	**MCH Initiatives**
Breastfeeding/nutrition/WIC Teen parenting Overcoming cultural barriers Expanding private sector links Clergy & health connections Other outreach activities Increasing social support Staff training Building coalitions & partnerships	Tracking systems Implement/support education services for special MCH problems Prepare, publish & distribute reports Development of models Provide infrastructure/capacity for MCH functions Staff training Support of continuing education Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Profiles of provider attitudes, knowledge & practices Identify & report access barriers

Description

Certified lactation consultants visit the participating hospital to pick up referral forms of WIC moms who are medically eligible to breastfeed from nursing staff on the obstetrics and postpartum units. The lactation educator visits these moms in their hospital rooms and offers assistance on breast-feeding. This is done six days/week in order not to miss any eligible patients. During the visit, an appointment is arranged for mom and baby to receive WIC certification soon after discharge. A communication sheet that includes assessment of mother and baby breast-feeding skills and recommendations is provided to the unit nursing staff so they can follow up before discharge. After discharge a follow-up phone call by a registered dietitian lactation educator is made to the breast-feeding mom at home within two days. Problems/concerns are identified and verification of the WIC appointment is made. Another phone call is made two weeks postpartum when the infant is going through a growth spurt to offer encouragement and problem-solve concerns. Mom and baby are invited to attend a breast-feeding support group. The space, transportation, and baby-sitting are provided free by a local church. Referrals are made to the MSS lactation educator who can visit in the home if needed. At one-month postpartum, a survey is sent to the mom. At two months postpartum the mom and infant are seen in the WIC clinic and verification of breast-feeding status is done.

Objectives

1. Support the initiation of breast-feeding among WIC participants so that mothers are making an informed decision regarding breast or bottle-feeding.
2. To increase breast-feeding rates among WIC participants.
3. To identify barriers to breast-feeding initiation and to develop strategies to overcome these barriers.
4. Utilize information learned from initiation through follow-up to improve current breast-feeding promotion activities.
5. Utilize information learned to seek future funding to address these barriers.

Barriers Encountered

1. Administrative concern within the local agency related to possible liability associated with utilizing contract staff working under our umbrella and providing service within another agency (hospital).
2. Psychosocial attitudes toward breast-feeding in West Michigan. Fear that the WIC moms would be intimidated.
3. Resistance from staff in the hospital postpartum unit. The apparent lack of support for breast-feeding among the nursing staff and the extra work involved in identifying the eligible WIC moms and follow-through needed for documentation since our contract staff were not allowed to access the patients' records.
4. Formula companies with give-aways are difficult to compete with in postpartum units.

Strategies to Overcome

The WIC participant signs a release of liability form. Only staff that are RN and Certified Lactation Consultants (CLC) were utilized for the project. Staff provided evidence of medical malpractice insurance.

A mandatory survey was provided as follow-up to make sure that the mothers did not feel coerced by staff.

The lactation consultants talked and shared with staff one-on-one to gain acceptance and buy-in. Sharing pilot results with unit staff. Working together with hospital staff for activities during World breast-feeding week August 1-7. Providing promotional materials to unit staff.

Medela, maker of breast pumps stepped up and provided breast-feeding give-aways. Michigan WIC provided breast pumps as needed. The KCHD MSS program lactation consultant provided in-home consultation and distribution of electric breast pumps to encourage moms to use breast milk if they wanted to bottle-feed or had issues around putting baby to breast.

Funding Source: Other Federal
Description of other sources: For three-month pilot project
Budget: $4,320.00

Role of Health Department:

1. Designed the project.
2. Sought and secured funding.
3. Hired staff.
4. Coordinated inter and intra agency program staff to gain cooperation and consensus.
5. Developed teaching tools.
6. Provided tracking and follow-up of participants.

Accomplishments:

1. Successful collaboration and cooperation between agencies in addressing the breast-feeding needs of WIC clients and improving continuity of care.
2. Increase in breast-feeding rates of participants in the project.
3. Lessons learned can be used to improve content of breast-feeding classes and support groups.

Lessons Learned:

More up-front preparation time dedicated to preparing hospital personnel. We didn't realize the barriers to breast-feeding that existed on the hospital postpartum units. This was compounded by short hospital stays, nursing shortages, and inadequate orientation for some staff. Hospital staff needed more input on the teaching tools to gain acceptance.

We were unable to provide support in NICU as hoped. The demand for our services exceeded available staff time.

Universal Newborn Home Visits

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Replicated: Don't Know
Evaluated: Yes

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Essential MCH Functions:	**MCH Initiatives**
Expanding maternity services Home visiting	Universal newborn screening programs

Description

Registered nurses with specialized training and experience in public health, perinatal nursing, and lactation support provide home visits to newborns within three to five days of delivery and return visits at eight to ten days, six weeks, and as needed. Telephone follow-up occurs as needed and at six months to evaluate outcomes. Interpreters are available to facilitate communication.

Visits are educational/assessment with special emphasis on: care of a newborn, breast-feeding, SIDS prevention, day-care resources, growth and development, age-appropriate discipline, well-child care, immunizations, child-spacing/contraception, car seat safety, environmental safety and nutrition. Any medical concerns or abnormal findings are reported to the physician.

An educational/incentive item (book, video, toy) is given to each family during the home visit. Books and videos include a variety of parenting and breast-feeding topics and some are available in Spanish. Toys are developmentally appropriate.

Objectives

The goal is to provide all new parents with the information, support and resources necessary to raise an emotionally, intellectually and physically healthy child. SmartStart's goal is to have every child enter school healthy, safe and ready to succeed. Although the SmartStart budget has been reduced, the partnership has funded this grant for the next 12 months.

Barriers Encountered

Continued funding of staff.

Strategies to Overcome

Working with grant sources and insurance companies to fund the project.

Funding Source: Other Federal
Budget: $800,000.00

Role of Health Department:

Outcome activities are being monitored by a six-month follow-up. Budget expenditures being monitored.

Accomplishments:

1. Hiring, training of seven nurses, three interpreters and one management support person.
2. In-service programs to hospitals and medical groups.
3. Ordering of supplies including large number of incentives.

Lessons Learned:

Received well by mothers.

Family Planning Outreach

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Replicated: Don't Know
Evaluated: No

Essential MCH Functions:	MCH Initiatives
Family planning Other outreach activities	Implement/support education services for special MCH problems Development of models Develop & promote MCH agenda and YR2010 National Objectives Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Detention settings, foster care, mental health facilities

Description

The grant provided funds to offer Depo Provera under a Delayed Exam Protocol to female inmates soon to be released from the County Detention facility. The plan provides education to both inmates and detention facility staff and provides discharge packets which included male and female condoms, spermicide, information about Depo Provera and other methods of contraception, and about how to contact the health department Family Planning Clinic for continued service after release. The packets also contained a small incentive gift, such as travel-size lotions, shampoo, etc., which were donated.

Objectives

1. By June, 2001 to serve 216 women in a detention facility who are at risk of unintended pregnancy when they are released back into the community.
2. By June 2001, to provide one staff in-service for facility staff on contraception and the prevention of STDs.
3. By June, 2001 to provide ten monthly classes to the female inmates of the facility to answer their question about birth control and the prevention of STDs.
4. By December, 2001, collect data on the rate of return for full services to the Tri-County Family Planning clinic by women seen at the facility.

Barriers Encountered

Our most "insurmountable" difficulty from the start was in obtaining a consistent support system at the jail. The staff turnover from the top down was constant. We tried having someone post a sign where the women were confined to let the women know about the availability of our service. This was only minimally effective. Frequently the staff forgot to post the sign in spite of our calls to remind them. Security precautions prevent posting the actual day and time of our visit, to prevent inmates knowing when visitors would be coming and conceivably arrange for contraband to be brought into the jail.

Initially, the facility nurse, who had previously been a deputy, appeared to be very invested in our project. She told of high need and was instrumental in getting the approval of her supervisor and the Warden to start the project. She suggested we come on a particular morning of the week, but it turned out this was the worst possible time for the inmates. It was immediately after breakfast and at the time they had to report for their jobs. In order to be freed from their job even for a short period of time, they must obtain prior approval from their deputy; but because they wouldn't know ahead of time that we were coming, they couldn't obtain the approval. We befriended a deputy or two who would try to recruit women, but the short time frame just didn't work well for very many. One of the nurses suggested visits in the early afternoon, which were only slightly more effective. He also was instrumental in locating a place for us to provide a short class for the inmates about contraception, but recruiting the women continued to be almost impossible. We also suggested visiting in the evening, but found the inmates' evenings to be fully scheduled.

Strategies to Overcome

Persistent and repeated attempts to contact the Health Services Administrator-Nurse (HSA) had to be made each month in order to secure permission and schedule a time for our visit. This made it impossible for our staff to plan the time in our clinic schedules for the staff to go to the jail. However, we persisted every month, "beating down the door," so to speak until we were able to get approval for a time for a visit.

We now know that written permission from higher up and longer planning that involved the facility social workers, chaplains, and the entire deputy system is a necessity. The verbal permission to do the project was lost with the continual staff changes that occurred.

Funding Source: Other Federal
Description of other sources: Title X special project funding
Budget: $15,000.00

Role of Health Department:

This project originated, was planned, implemented and evaluated with the women's health section of the Tri-County Health Department.

Accomplishments:

We were able to reach 53 women during the time we worked with the facility. Using a variety of approaches to recruit women and with the aid of some of the nurses and deputies who were very supportive of our efforts, we were able to provide service to a very needy population.

Lessons Learned:

Had we realized the amount of staff turnover and administrative changes that take place, we would have planned differently and would have tried to contract someone higher up to facilitate our entry into the facility and provide a means to coordinate and schedule our visits. We would probably have asked for a written approval from the Warden instead of verbal; it may have held more weight with the new Warden and the several HSAs we encountered during the one year of our project.

Lead Poisoning Prevention Awareness Campaign

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Replicated: Don't Know
Evaluated: No

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Essential MCH Functions:	MCH Initiatives
Home visiting Lead poisoning Schools & health connections Strategic planning Reshaping urban MCH Building coalitions & partnerships Building MCH data capacity	Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs

Description

City vehicles can be found everywhere on a daily basis throughout the city of Hartford. The department used this to our advantage to promote a culturally appropriate awareness program about lead poisoning and its impact on our community. The health department developed an educational awareness campaign on the sides of Department of Public Works (DPW) sanitation trucks. The city Departments of Health, Public Works and Housing and Community Development worked together to arrange the use of city sanitation trucks to carry the messages. The 4 x 8 foot signs show a mother playing with a child and the words, "When painting or renovating your home, work lead safe" in both English and Spanish. The Campaign is aimed at educating parents about the harmful effects that lead poisoning can cause to children, one of the most common but preventable public health problems today. A total of 13 signs have been affixed to Hartford sanitation trucks. Each of these vehicles is very visible to our residents. Every day these vehicles can be found driving into our neighborhoods, canvassing every street in the city of Hartford. These vehicles represent a substantial fleet that can be used to promote increased awareness of our program in order to strengthen efforts to decrease the numbers of children that have been diagnosed with pediatric lead exposure.

Objectives

1. To maximize existing resources to sustain an educational awareness program indefinitely, at no additional cost.
2. To improve interdepartmental relationships, for promotion of the "common good," while utilizing existing expertise from within each department to strengthen community awareness messages.
3. To make city vehicles more "public-friendly."
4. To redefine how educational and or awareness messages are provided to the public in the city of Hartford.
5. To utilize city vehicles for maximum awareness potential.
6. To make city vehicles an extension of the programs that departments represent.
7. To provide all city departments a low cost venue to reach the public.
8. To promote awareness of activates sponsored or performed by city departments.

Barriers Encountered

1. This educational awareness concept utilizing city vehicles had never been developed and implemented before.
2. Overcoming concerns and objections that the DPW had concerning this educational awareness initiative.
3. Passing a city resolution authorizing city vehicles to be utilized to highlight an awareness message about lead poisoning.
4. Strengthening partnerships between three different city departments to make the campaign a success.
5. Gaining approval from national and local sponsors of this collaborative effort.

Strategies to Overcome

1. Focused on the positives and did not let detractors limit our ability to make this educational awareness campaign a reality.
2. Met with DPW to discuss any concerns and developed a prototype for review by appropriate personnel.

3. Worked with city leaders to pass a resolution authorizing us to utilize city vehicles for this purpose.
4. Every department was kept informed of the progress of this initiative. Each department had the opportunity to provide input into the messages. Utilized the strengths of each department's personnel to accomplish our objective.
5. Actively pursued the National Safety Council for permission to utilize a message that had been developed previously by the agency. Made it a point to include various Federal/State and local agencies.

Funding Source: Other
Description of other sources: U.S. Department of Housing and Urban Development
Budget: $7,500.00

Role of Health Department:
The health department took the lead role in this project, conceptualized the concept, initiated the partnerships with other city departments, worked with city leaders to support the initiative, developed, implemented, and provided project oversight.

Accomplishments:
The health department, utilizing city vehicles, developed an educational awareness campaign on the sides of DPW sanitation trucks. The city Departments of Health, Public Works and Housing and Community Development worked together to arrange the use of city sanitation trucks to carry the messages. A total of 13 signs have been affixed to Hartford sanitation trucks.

Lessons Learned:
Coordination and collaboration have been key to the success of this educational initiative.

Postpartum/Newborn Home Visitation Program

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Replicated: Don't Know
Evaluated: Don't Know

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Essential MCH Functions:	MCH Initiatives
Home visiting	Prepare, publish & distribute reports Develop & promote MCH agenda and YR2010 National Objectives Provide outreach services Universal newborn screening programs Identify & report access barriers

Description

A home visitation program was initiated in 1995 for mothers and babies who were discharged within twenty four hours of delivery. The public health nurse provides a comprehensive postpartum and newborn physical assessment. Included in the newborn assessment is the Newborn Body Chemistry Screening. To ensure a timely visit, the referral is sent to the Public Health Nurse (PHN) within 24 hours of discharge from the hospital. The PHN then contacts the client to arrange a home visit between two and four days from hospital release.

Objectives

1. To ensure the optimal health and well-being of both mother and baby, as well as the family as a whole.
2. To identify problems and make appropriate referrals for resources and additional services.
3. To provide mom reinforcement of the health teaching that she received while in the hospital.
4. To facilitate communication and follow-up appointments with appropriate health care providers.

Barriers Encountered

1. Staff training: health department staff were scheduled to shadow and work with hospital staff on the OB/GYN and newborn units.
2. Clinic and hospital staff awareness of the program: orientation was provided by the PHNs for the clinic and hospital staff. It was felt that they needed to be able to present the program to the women when they were pregnant and attending prenatal appointments or while they were in the hospital for delivery. From past experience the PHNs knew that if the family has more information before the visit, the PHN would be better received.
3. Public Awareness: the mother needed to know about the program so that it would not be viewed as a threat or an invasion of privacy. Many times clients are skeptical of the reason for a home visit.

Strategies to Overcome

1. Working with hospital staff and being flexible with health department staff schedules was a major need. If there was a high census for deliveries, extra PHNs could be called in order to have the observational experiences. If the census was low, PHNs assigned for that period may not have had the opportunity for good observational experiences. This would necessitate rescheduling at another time.
2. PHNs made visits to clinics and to the hospital units to present information about the purpose of the program. The expectations of the home visit were discussed. A flier was designed that the staff was asked to share with the clients. Sought hospitals' input on what they felt would be helpful and learned more about what teaching was provided prior to discharge, allowed for a more thorough home assessment.
3. The flier that explained the program was very helpful. If clinic staff and/or hospital staff were too busy to describe the program the client did have some information to review. The health department also has a prenatal care coordination home visitation program and the PHNs would discuss the after discharge visits with the clients. Probably the greatest marketing tool has been word of mouth.

Funding Source: Local Government
Budget: $0.00

Role of Health Department:
The health department PHNs provide this program.

Accomplishments:
The mothers have provided very positive feedback about having the opportunity to have a nurse visit them in the home. It has given them the opportunity to ask questions and become more comfortable in handling the new baby. Hospital and clinic staff have also indicated that there is the need for continuing education once the mom leaves the hospital. There are so many things happening when the mom is in the hospital, as well as being emotionally and physically exhausted, that teaching is often not well received. Time constraints are also a major reason that not as thorough teaching can be provided. Visiting in the home in a more relaxed and familiar surrounding is more conducive to helping mom understand what is happening to her, as well as the newborn. Because of this, in June 2001, the program expanded to all moms who deliver regardless of the length of the hospital stay following delivery.

Lessons Learned:
1. Physical assessment can identify serious health risks that require immediate medical attention, i.e., febrile episodes for mom meaning possible infection, newborn feeding problems, newborn jaundice, newborn heart murmurs, abnormal newborn screen.
2. The education and training that mom may have received in the hospital needs to be reinforced and demonstrated in a more familiar surrounding. It is also helpful to have another family member present so that the infant care can be shared in order to give mom a respite.
3. Socioeconomic concerns are not always discussed in the clinical setting. Home visits often provide a clearer picture of the need for resources and referrals.
4. Prenatal education and medical care is paramount in the care of the mom and newborn. It is crucial in the delivery of a healthy baby.

Comenzando Bien Education Project

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Replicated: Yes
Evaluated: No

Essential MCH Functions:	**MCH Initiatives**
Family planning Prenatal care Expanding maternity services Home visiting Low birthweight/infant mortality Substance abuse prevention Breastfeeding/nutrition/WIC Overcoming cultural barriers Staff training	Culturally appropriate health education materials/programs Staff training Support of continuing education Identify high-risk/hard-to-reach populations & methods to serve them Identify & report access barriers

Description

"Comenzando Bien" is an orientation and training program for health care professionals who provide prenatal care and education to Hispanic women. Four people from the Hinds County Health Department attended this training designed to help participants convey health messages to Hispanic women. The messages to be communicated are the importance of having a healthy pregnancy, taking advantage of prenatal care, learn what prenatal care involves, nutrition during pregnancy, physical stress during pregnancy, relationships during pregnancy, and drug, alcohol and tobacco use during pregnancy. This activity was promoted and endorsed by the Mississippi State Department of Health and sponsored by the March of Dimes. Hinds County participants were targeted for the training. Hinds County has the highest number of births to Hispanics in Mississippi, and the State has the third fastest growing population of Hispanics in the country.

Objectives

By the end of the activity, at least four health care professionals would have attended the program and be able to:

1. Become familiar with key Hispanic and infant health statistics.
2. Understand how cultural issues can be a barrier for Hispanic women seeking prenatal care.
3. Explain the philosophy behind and understand the curriculum of Comenzando Bien.
4. Define the roles and responsibilities for program implementation and evaluation.
5. Identify ways to implement Comenzando Bien in the community.

Barriers Encountered

1. Getting a Hispanic group together for prenatal classes.
2. No time for clinic nurses to implement this program into the community.
3. Only four participants from Hinds County attended due to severe staff shortage.
4. Lack of confidence in starting something new.

Strategies to Overcome

1. Hiring an interpreter to implement this program in the local health department.
2. One-on-one training with the local clinic nurses who provide direct patient care to the Hispanic population.

Funding Source: Local Government
Description of other sources: March of Dimes
Budget: $24,200.00

Role of Health Department:

1. Promoting participation in the training to the local health department staff.

2. Disseminating the training modules to the local clinic staff.
3. Developing an evaluation tool.

Accomplishments:

1. Scheduling all appointments for the Hispanic women on the same day and utilizing an interpreter.
2. Ordering medical English to Spanish books for each clinic.
3. Offering medical Spanish classes for nurses and clinicians.

Lessons Learned:

Need a tracking system to evaluate how effective the training was and how the materials were utilized.

Early Start Prenatal Program

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Evaluated: No

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Essential MCH Functions:	MCH Initiatives
Prenatal care	Community perceptions of health problems/needs
Building coalitions & partnerships	Implement/support education services for special MCH problems

Description

The major goal of the Early Start Prenatal Program is to maintain or increase the 90 percent of births with early entrance and adequate prenatal care as stated in the Healthy People 2010 objective.

There are no comprehensive early trimester prenatal education programs available in Knox County to offer to all pregnant women. Some area hospitals and community programs offer education concerning preterm labor, labor and delivery, anesthesiology, and parenting nutrition only to those women delivering in their facility.

Early Start Prenatal workshop will consist of three workshop series. Each series will be comprised of four classes. There will be one class for four consecutive Tuesday nights. The workshops will be held during the evening to accommodate the pregnant women who work. Each series will register a maximum of thirty women with an additional thirty support persons (mothers or fathers). The project manager and staff concluded that the first workshop series would begin in March and end in September with two-month intervals between each series.

The Knox County Health Department will work in a collaborative effort with Healthy Families (Helen Ross McNabb), Stork's Nest (zeta Phi Beta and March of Dimes), and the University of Tennessee Medical Center (OB/GYN) to provide education and a referral system for additional services. Classes will be taught by nurse practitioners, registered nurses, health educators and licensed, registered dietitians.

Objectives

1. Prenatal provider agencies or individuals will refer 30 people into each class series.
2. Eight-five percent of class participants will respond through questionnaire about implementing at least one life style change at completion of the series.
3. At the conclusion of each four-week series, 80 percent of participants will attend three or more classes.
4. At the conclusion of each four-week series, 80 percent of all participants will have attended an appointment, or will have scheduled an appointment with a medical care provider.

Barriers Encountered

1. Participants may be more than 24 weeks gestation.
2. Strictly volunteer.
3. Classes are for any pregnant women in Knox County regardless of age, race, socioeconomic, TennCare insured or private insurance. All classes are free of charge.

Strategies to Overcome

1. Encouraging providers to refer patients at first prenatal visit.
2. Stress to providers and agencies that any pregnant woman throughout Knox County can benefit from this educational series.
3. Presenting participants with a certificate for attendance to turn back in to their provider.

Funding Source: Private Source
Description of other sources: March of Dimes Grant
Budget: $4,000.00

Role of Health Department:
Health department staff designed the program, obtained funding, coordinated activities, and contacted prenatal providers and agencies providing services. Nurses, health educators, and nutrition staff facilitated the education series, which was held at the health department.

Accomplishments:
In the two sessions conducted as of August 1, 2001, 52 prenatal patients and 22 support persons participated in the series of four classes. In the workshop evaluation given out at the June 2001 series, 21 of 26 participants felt the workshop was helpful. Many participants gave excellent suggestions for future workshops.

Lessons Learned:
Community assessment of gaps in services often provides new opportunities for health education and prevention activities. Collaboration with community partners contributes to a more comprehensive program.

Maternity Program

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Replicated: Don't Know
Evaluated: Yes

Essential MCH Functions:	MCH Initiatives
Family planning Prenatal care Home visiting Low birthweight/infant mortality Substance abuse prevention Breastfeeding/nutrition/WIC Immunizations Early intervention/zero to three EPSDT/screening Teen pregnancy Family violence Overcoming cultural barriers Case coordination	Culturally appropriate health education materials/programs Develop & promote MCH agenda and YR2010 National Objectives

Description

OB screening for women consists of obtaining the medical, family, social, OB, infection, genetic, substance abuse, and domestic violence history. An appropriate individualized problem-oriented counseling, referral, case management and anticipatory guidance is provided on site by the RN with, if necessary, the Spanish interpreter. Currently, there are three full-time nurses including a nurse team leader. Comprehensive routine prenatal labs are obtained during this visit. The patient receives multivitamins with folic acid if she is in the first trimester or prenatal vitamins, which also include folic acid, if she is beyond the first trimester. During this visit a nursing assessment including nutrition, BP, edema checks, weight, height, fetal heart tones, fundal height, fetal lie and patient problems is completed. Nurses consult with the OB, nutritionist or social worker if problems are identified. Referrals are made to the OB clinic or the hospital as appropriate. All patients are referred to home visiting for routine prenatal, postpartum and newborn assessments. Home visits for identified problems are completed as needed. The patient also is screened by the social worker and appropriate follow-up and referrals are completed. The patient receives WIC services the same day of the screening. The patient's OB appointment is scheduled before she leaves the clinic. In addition, a return monthly nurse visit and appropriate repeat labs are scheduled at the health department. An RN visits the patient in the hospital during the antepartum and postpartum periods. The RN assists with linking the patient with needed services such as a home visiting, family planning, WIC and a two week newborn visit after discharge. The RN also obtains needed perinatal data for the perinatal profile portion of the Urban Health Initiative Grant. Since the infant is born a U.S. citizen, he or she is eligible for SCHIP, which will cover newborn care. The Emergency Medical Card covers the mother's six-week postpartum visit.

Objectives

1. To provide 100 percent of patients seen in the center who have a positive pregnancy test, a maternity nurse visit for assessment, problem oriented, anticipatory guidance counseling and access to prenatal care the same day that the pregnancy test is positive.
2. To enroll 90 percent of prenatal patients during the first trimester of pregnancy.
3. To enroll no more than 10 percent of prenatal patients in the third trimester of pregnancy.
4. To have at least 75 percent of the newborns receive a two-week newborn visit.
5. To have at least 65 percent of the mothers receive a postpartum clinic visit.

Barriers Encountered

1. Most Latino patients are already beyond the first trimester when they come to the U.S. and present to the health department clinic for prenatal care.
2. There are not enough interpreters to provide needed services.

Strategies to Overcome
Patients are taught about the importance of early prenatal care for subsequent pregnancies. The administrator of the program collaborates with the Urban County Government Director of Immigrant Services to inform the Hispanic community of the importance of early prenatal care and other preventive health services including preconceptional health, cancer screening and well child services. Aggressive recruitment is in progress to hire Spanish interpreters.

Funding Source: Local Government
Description of other sources: State, MCH Block, 330 funds
Budget: $588,500.00

Role of Health Department:
Health department staff identified the increased need for prenatal services for Latino patients. Ninety-nine percent of the non-Medicaid patients enrolled in the Maternity Program are Latino. They are ineligible for Medicaid because they are not U.S. citizens. A contract between the health department and the University of Kentucky Medical Center Bluegrass High Risk Obstetrics Clinic has been negotiated. The health department will pay the obstetricians an amount less than cost per patient from State funds for the OB to provide prenatal care for 265 patients. The patient is responsible for paying $100.00 per visit . The target is to collect $900.00 from the patient to be applied to delivery costs. If the patient cannot pay the $900.00, the financial counselor completes a financial screening and adjusts the payment according to the patient's ability to pay. This is an incentive for the pregnant woman to apply for the time limited – "Emergency Medical Card." Currently only about 50 percent of the women apply for the card. Patients will not be turned away due to inability to pay. When the patient applies for and receives the Emergency Medical Card during the last month of pregnancy, the Medical Card will pay for delivery and newborn care. The money that the patient has paid toward delivery will be refunded, if she does not have outstanding bills for prenatal care beyond routine care covered by the health department, or outstanding bills in other clinics. An additional full-time Spanish interpreter was hired by the health department to assist current interpreters at the health department site. Interpreters are now available 36.0 hours per week prior to adding two 18.0 hour interpreter positions to assist the nursing, clerical and social service staff to communicate during the nursing preliminary work up, nursing education, counseling clinic visit and case management. The interpreter also assists clerical staff to determine program eligibility and schedule appointments.

Accomplishments:
Negotiating a contract with the University of Kentucky Bluegrass High Risk OB Clinic to provide prenatal care for 265 non-Medicaid patients, which is paid with State funds, even though this fee does not cover the clinic's entire cost.

Lessons Learned:
Patients did not keep prenatal appointments because they could not afford to pay the $100.00 per OB visit fee. Patients were asked to reschedule appointments if they did not have the $100 for the OB visit. Health department staff worked with the Bluegrass clinic administrator and obstetrician to overcome these barriers. More interpreters are needed to meet the need. The health department staff and the Bluegrass clinic have diligently worked together to assure that patients receive prenatal care and to eliminate identified barriers to care.

Teen Outreach Clinic

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Replicated: Don't Know
Evaluated: Yes

Essential MCH Functions:	**MCH Initiatives**
Teen pregnancy Teen parenting Other outreach activities Building coalitions & partnerships	none

Description

This is a three year block grant designed to reach adolescent males and females with education regarding HIV/AIDS, STDs, contraceptive choices, abstinence, genital and breast self-exam, and other reproductive health issues. This first year has targeted teens who have been court-ordered to such counseling and to teens residing in the Ouachita Children's Center. The services are being expanded to include any teens who reside in the county. A comprehensive review of the above topics are discussed in a group setting prior to offering services. If a client desires services, then further individualized counseling is provided. A full physical exam is available along with STD testing and contraceptives being issued.

Objectives

1. Reduce the incidence of STDs and undesired pregnancy in the target population.
2. Increase individual knowledge of the following:
   A. What an STD is.
   B. How STDs are acquired.
   C. How to protect yourself from STDs.
   D. What "sex" is.
   E. What abstinence is and why I should choose it.
   F. The symptoms of STDs, how I get tested for them, and the treatment for them.
   G. What my other disease and pregnancy prevention options are and how they work.
3. Each participant is given a pre- and post-test on the above subjects to evaluate the efficacy of the education.
4. Follow-up "Q and A" will be done looking at the STD and pregnancy rates of this group, as well as compliance rates for those who choose contraceptive methods other than abstinence.

Barriers Encountered

1. Finding volunteers to staff the clinic, which is operated after regular working hours.

Strategies to Overcome

1. The staff in the local health unit was involved in the initial planning of this program and were allowed to present solutions to the staffing issue. They each agreed that this was important and agreed to rotate staffing among themselves as long as there would be someone available to do the counseling.
2. OCC contracted a counselor each week who also issues the contraceptives at the end of each clinic.

Funding Source: MCH block grant
Budget: $0.00

Role of Health Department:

The local health unit provides the following:
1. Staff nurse to provide laboratory services.
2. RNP to offer clinical exams.

3. Physical facility for the clinic.
4. All forms, educational materials and contraceptives.

Accomplishments:
1. Increased adolescent participation in reproductive health services.
2. Initiation of direct outreach to male adolescents.
3. Increased knowledge of adolescents regarding STDs contraception and abstinence.

Lessons Learned:
1. Education and access are the most important needs of our citizens.
2. Formal contracting with volunteers insures compliance and attendance.
3. This type of clinic is an excellent resource for others (public and private sector) to implement.

Good Beginnings Never End

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Replicated: Don't Know
Evaluated: Yes

Essential MCH Functions:	MCH Initiatives
Immunizations Overcoming cultural barriers Expanding private sector links Other outreach activities Increasing social support Increasing access to Medicaid Staff training Establishing new collaborative partnerships Building coalitions & partnerships	Culturally appropriate health education materials/programs Promote compatible, integrated services system initiatives Provide outreach services Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them

Description

The Good Beginnings Never Ends project is a collaborative effort of seven agencies in Long Beach, each of whom consider improving the quality of life for children a priority. The project targeted one ZIP code, where there are inadequate child care resources, a high level of residents at or below the poverty level, and a high percentage of non-English speaking residents. The project targets licensed, unlicensed, and license-exempt family home day care providers, with the aim of improving the quality of the day care being provided and the linkages to supplemental services (such as health care) for families utilizing day care. Services are delivered via outreach by project staff to day care providers in their homes.

Objectives

The project goal was to provide outreach, educational stimulation, and improved access to health care and other resources for 150 targeted family child care providers. The specific measurable objectives included:
1. 50 percent of the targeted providers will increase their knowledge of family child care skills (such as child safety and basic first aid) as evidenced by pre and post training tests.
2. As evidenced by the Family Day Care Rating Scale, 25 percent of the providers will demonstrate an improved score (indicating increased literacy behaviors and prereading skills).
3. An additional 10 percent of the children receiving day care services from the targeted providers will be up-to-date for immunizations.
4. 50 percent of the targeted providers who are unlicensed or license-exempt will start the process to become licensed.

Barriers Encountered

Initially, the greatest barrier was identifying which agency would lead. Collaborative partners were easy to identify, and included the local community college, the city's library department, a local community clinic with a long history of providing outreach and education and collaboration, the local school district Head Start program, a community-based agency specializing in outreach to Southeast Asian populations, and a local child care agency. Finding the agency with the best "fit" took some time.
Another barrier was locating unlicensed child care providers since they don't register with the local resource and referral agency.

Strategies to Overcome

One of the collaborative partners, Long Beach City College, volunteered to be the lead agency, primarily because the scope of the project fit within the services already provided (to locate and improve the quality of child care being provided for TANF families). They would also receive a great deal of support from the other partners in designing the project and writing the proposal.

Identifying unlicensed providers continues to be problematic; those who have been identified and are receiving project services believe the project to be very beneficial, and are informally spreading the word. Other outreach efforts through project activities by the collaborative partners help to identify additional unlicensed participants.

Funding Source: Local Government
Description of other sources: Prop 10 Tax Initiative Funds
Budget: $296,141.00

Role of Health Department:
Long Beach Department of Health and Human Services (LBDHHS) provided demographic data on the targeted ZIP code and the MCH Director participated in writing the proposal and developing objectives. LBDHHS subcontracts with Long Beach City College to do immunization training and tracking, as well as providing in-kind support to ensure enrollment of eligible children into Medicaid and SCHIP.

Accomplishments:
Accomplishment of the stated objectives in year one.
Expansion to additional ZIP codes in year two.
Developing a strong collaborative partnership, which has led to additional Proposition 10 funded collaborative projects.

Lessons Learned:
The value of collaboration; a lot more can be accomplished through partnership.

Black Infant Health

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Replicated: Yes
Evaluated: Yes

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Essential MCH Functions:

- Family planning
- Prenatal care
- Expanding maternity services
- Home visiting
- Low birthweight/infant mortality
- Substance abuse prevention
- Breastfeeding/nutrition/WIC
- Immunizations
- Early intervention/zero to three
- EPSDT/screening
- Expanded child health services
- Injury (including child abuse)
- Lead poisoning
- Children with special needs
- Teen pregnancy
- Teen parenting
- Family violence
- Overcoming cultural barriers
- Reducing transportation barriers
- Expanding private sector links
- Clergy & health connections
- Schools & health connections
- One-stop shopping locations
- Mobile clinics for outreach
- Other outreach activities
- Increasing social support
- Case coordination
- Increasing access to Medicaid
- Eliminating Health Disparities

MCH Initiatives

- Hotlines, print materials, media campaigns
- Culturally appropriate health education materials/programs
- Implement/support education services for special MCH problems
- Provide infrastructure/capacity for MCH functions
- Provide outreach services
- Transportation & oter access-enabling services
- Referral systems, resource directories, advertising, enrollment assistance
- Identify high-risk/hard-to-reach populations & methods to serve them
- Provide, arrange, administer direct services

Description

The Los Angeles County Black Infant Health Program (BIH) is designed to address the health disparities in birth outcomes of African-Americans compared to other racial/ethnic groups. Two models are employed: Prenatal Care Outcome (PCO) and Social Support and Empowerment (SSE). PCO utilizes community health outreach workers to identify potential families in the community in need of perinatal services. Intensive outreach is conducted to locate high-risk pregnant women, document their health and social support needs and link them to services. SSE provides high-risk women with the support, advocacy and assistance they and their children need through a series of eight classes. This model helps women who feel powerless in their own lives to identify and uncover their inner strengths and utilize these strengths as a launching pad for empowerment.

Objectives

1. Reduce African-American infant mortality through a comprehensive, community-based effort by assuring that at-risk pregnant and parenting women and their infants and children up to age two have access to quality maternal and child health services.
2. Reduce the number of African-American infants born with birthweights below <500 grams.
3. Reduce the number of African-American women who smoke, use alcohol, and/or nonprescription drugs during pregnancy.
4. Reduce the number of African-American babies who die due to SIDS.
5. Increase breast-feeding rates of pregnant/postpartum African-American women to improve the health of their infants.

Barriers Encountered

In order to carry out this program through subcontractors we encountered the following barriers:

1. Subcontractors have difficulty recruiting clients for both PCO and SSE.
2. The models need to be implemented in a specific manner-based on State guidelines.
3. The data collection to document the program outcomes is extensive and therefore labor intensive.

Strategies to Overcome

The two contracted CBOs (Great Beginnings for Black Babies and Harbor UCLA Research and Education Institute) have their roots deep in the community, and they both have the trust of the populace, so recruiting clients, while at times challenging, has been dealt with by seeking out new locations in partnership with the Los Angeles County Maternal, Child, and Adolescent Health (MCAH) Programs.

The State MCH has provided training to facilitate overcoming both these barriers. As contractors see the "fruit of their labors" they continue to diligently comply with program requirements.

Funding Source: Local Government, General state funds, MCH block grant

Budget: $1,915,010.00

Role of Health Department:

MCAH contracts with two community-based organizations, that provide the direct services of the BIH program. MCAH provides contract monitoring and management, contract or training and serves as the liaison with the State MCH-BIH Program. A Request for Concept Papers (RFCP) will be released in July 2001, resulting in three new contracts for BIH sites in Los Angeles County. MCAH oversees the RFCP and contract award process.

Accomplishments:

San Diego State University serves as the official Evaluator for the Statewide BIH Programs.

According to SDSU data, over the past four years (July 1, 1996-June 30, 2000), client enrollment in California has steadily risen to 6,891, averaging 405 clients/BIH site. There have been 4,204 completed pregnancies and a 25 percent dropout rate.

In the period July 1, 1996-December 31, 1999, 85.4 percent of clients had babies of normal birthweight, 12.3 percent were low birthweight, and 2.3 percent were very low birthweight. During the same period, there was a gradual reduction in low birthweight babies with no change in risk - evidence that the program is positively impacting outcomes. In the same period, overall premature births (<37 weeks gestation) was 17.7 percent for clients entering BIH <12 weeks gestation. In 1999, premature births among BIH clients was 16.2 percent (<37 weeks), compared to premature births of 17.9 percent (<37 weeks) among women receiving Medi-Cal. These data are additional evidence that BIH is making a difference over time.

SDSU data have also shown that quality assurance efforts by dedicated BIH program outreach workers to secure pregnancy outcome data has improved from 5 percent missing outcomes in 1996 to 0.1 percent missing outcomes in 2000.

Lessons Learned:

1. A coordinated uniform approach across programs yields the maximum impact in improving the health and well-being of African-American women and their families.
2. A culturally competent curriculum focusing on social support and empowerment can impact the birth outcomes of women who participate in it.
3. Community Health Outreach Workers who reflect the community they work in can serve as a resource and link to connect pregnant and parenting women to appropriate services.

Leaders in Oral Health

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Evaluated: No

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Essential MCH Functions:

- Dental programs
- Overcoming cultural barriers
- Expanding private sector links
- Schools & health connections
- Other outreach activities
- Staff training
- Strategic planning
- Building coalitions & partnerships

MCH Initiatives

- Community perceptions of health problems/needs
- Hotlines, print materials, media campaigns
- Culturally appropriate health education materials/programs
- Implement/support education services for special MCH problems
- Prepare, publish & distribute reports
- Public advocacy for legislation & resources
- Newsletters, convening focus groups, advisory committees, networks
- Promote compatible, integrated services system initiatives
- Staff training
- Provide outreach services
- Referral systems, resource directories, advertising, enrollment assistance
- Identify high-risk/hard-to-reach populations & methods to serve them
- Provide, arrange, administer direct services
- Identify alternative resources to expand system capacity
- Identify & report access barriers

Description

Good oral health is crucial to overall health and well-being. Now more than ever, the link between oral health and general health is being confirmed and documented. The Madison Department of Public Health (MDPH) has made oral health a priority and employs a public health dental hygienist (Dental Health Specialist) to help assess the oral health needs of the community and assure they are met.

The MDPH Dental Health Specialist, along with the public health dental hygienist from Dane County, has identified community partners and developed collaborative programs to begin to meet the oral health needs of the community.

Objectives

The overall objective is to increase access to dental care for all in the community. The following data demonstrate how dental programming has increased access:

1. From 1997 to 2000, 665 children were seen in 10 locations and 2832 teeth were sealed.
2. In 1999, 365 children received comprehensive dental care at the city's Children's Free Dental Clinic.
3. From 1999 to 2001, the SEAL DANE school-based sealant program served 406 children in 15 schools, sealing 1258 teeth. Oral health education was provided for 2399 children.

Barriers Encountered

The greatest barrier is the lack of accurate information regarding oral health issues on the part of the general public, including the common perception that oral health is not an essential part of a person's general health. Every contact or potential community "partner" brings his or her own perspective to the table, which may or may not be accurate, informed or supportive.

Strategies to Overcome

The only way we have found to deal with this barrier is to continue to inform and educate in a manner that respects the perspectives and opinions of others. The community partners in our oral health programs are invited to participate in all aspects of the programs (from planning to recruitment of staff to "hands on" provision of service) so that they can directly experience the program from all perspectives. Many times this approach reaps great rewards for all "players."

Funding Source: Local Government, other: Prevention Block Grant funds
Description of other sources: Private sources: Optimists Club, Local Hospital and Clinic Foundations, Dane County, Dental Society, and Healthy Smiles for Wisconsin.
Budget: $83,000.00

Role of Health Department:
The Dental Health Specialist from the Madison Department of Public Health, in partnership with the Dane County public health dental hygienist, has taken the lead role in planning, implementing and evaluating the activities that constitute the MDPH dental program.

Accomplishments:
Assessment: 1996-97 "Make Your Smile Count Survey" assessed the dental needs of approximately 1500 Dane County school children.
2000 Oral Health Access Report on oral health needs and available resources. Community collaboration to address concerns and investigate solutions is ongoing.
Assurance: Dental Health Education, Emergency Care Triage and Referral are important aspects of the Dental Health Specialist's role. Dental assessments in the department's Well Child Clinic for the uninsured and the Refugee/Immigrant Clinic are also important. In the provision of oral health care outside of the department, "partnership" has been the key word. Oral health assessment, education and referral have been done at Neighborhood Child Health Clinics for low-income children, in partnership with county public health and private clinics and hospitals. Partnering with Head Start, MDPH has provided entry examinations that include a dental assessment and referral. The local technical college has provided operation space and staff for the city-funded Children's Free Dental Clinic. Partners in the Free Dental Sealant Programs included the public schools, the National Guard, and volunteer dentists. A partnership was established with a group of oral surgeons who provide free or low cost care for one client per week. Two of the largest dental groups in the county have partnered with public health to provide free or MA-covered care to 30-40 uninsured clients per month. A free dental clinic to meet emergency dental needs was established with partial funding by the city and is staffed by volunteer dentists. Partnering with the Hmong community resulted in a Baby Bottle Tooth Decay Flip Chart for use with Hmong WIC clients. The most recent partnership with the county Tobacco-Free Coalition produced a graphic poster showing a diseased mouth and gums with the words, "Looking for one more reason to quit smoking: How about gum disease."
Policy Development: The Dental Specialist is active at the local, state and national level. Local advocacy has led to increased funding and community support; new legislation to increase dental access is pending before the State legislature.

Lessons Learned:
The public health dental hygienists learned to be single-minded and persistent in including the oral health message into any and every health venue possible. In doing so, when opportunities present themselves and oral health becomes an issue (as it has been recently with the Surgeon General's Oral Health Report), oral health priorities can be in the forefront for funding, partnering, and other programming opportunities.

"WIC Makes breast-feeding Easy" Outreach Campaign

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Replicated: Don't Know
Evaluated: No

Essential MCH Functions:	MCH Initiatives
Breastfeeding/nutrition/WIC	Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Referral systems, resource directories, advertising, enrollment assistance

Description

The Dade County Health Department WIC Program (caseload: 50,000 clients/month) initiated in January 2000, a new outreach focus that emphasized provision of breast-feeding services as the strategy for promoting WIC to hospitals, medical professionals, and the public.

The project has three areas of emphasis: Networking with six local hospitals that serve high-risk target groups, visits to obstetrician offices, and community outreach efforts. The approach focuses on changing the perception, "WIC is where the formula is" to "WIC Makes breast-feeding Easy" and offers services, not just information on how to receive or refer to WIC. breast-feeding peer counselors, who had completed the WIC sponsored twenty-eight hour peer counselor breast-feeding training course, were hired. Thus, the volunteer peer counselors (many are WIC mothers) had an opportunity to receive paid employment utilizing funds previously budgeted for outreach.

breast-feeding peer counselors visit the postpartum floors of six local hospitals. If a mother wishes to breastfeed she receives help right away, if not, she learns how to get nutrition support for her and her baby through WIC. Peer counselors give the WIC breast-feeding help line to those women who initiated lactation in the hospital and provide follow-up telephone calls support/encouragement to those that may experience problems initiating breast-feeding. Mothers who need specialized lactation support are referred to a WIC lactation specialist for an individualized consultation. This service is highly welcomed by the hospital staff and requests for similar partnerships have been made by other hospitals.

A peer counselor also goes door to door to obstetrician and physicians' offices explaining the benefits of WIC services and the application process. This approach focuses on changing their perceptions. We explain that WIC services include professional, nutritional, consultations, and education, professional lactation consultations to individuals in need, breast pump loan program, 24-hour breast-feeding help line, breast-feeding classes for clients and professionals, and volunteer breast-feeding peer counselors. Each doctor receives a professional package that includes applications, brochures on how WIC works, posters for the breast-feeding help line, breast-feeding and nutritional materials, brochures for waiting room, and a contact person in WIC who will support them and their efforts to promote breast-feeding and nutrition. Obstetrician visits are the primary focus to increase first trimester entry into WIC and percent of WIC infants initially breast fed.

Community outreach includes displays at local health and baby fairs, baby store displays, and breast-feeding classes at local clinics and Baby's R Us stores. The WIC display includes an educational true and false trivia game to win prizes. Most prizes have a breast-feeding message with the WIC appointment number imprinted. Multilingual bus cards with the message "WIC Makes breast-feeding Easy" and WIC outreach posters are displayed on Metro buses and the Metro rail stations throughout the county.

Objectives

The "WIC Makes breast-feeding Easy" outreach strategy was designed to improve key performance indicators measured by the state for each local WIC agency:

1. Number of participants per month.
2. Percent of low birthweight infants for WIC clients.
3. Percent of infants breast fed.
4. Percent of WIC infants initially breast fed.

5. Percent of first trimester entry into WIC.

Barriers Encountered

The greatest barrier has been insuring the appropriate educational material for health fairs and to encourage participation at our table. We often go into fairs with a variety of participants ranging greatly in age, ethnicity, educational level, and language. Other organizations attending fairs have great give away prizes and therefore have great participation at their table. We needed to bring the participants to our table and provide them with interesting educational material that would meet them at their level.

Strategies to Overcome

The first thing we did to overcome this variation was to create the trivia game with a multilingual approach. We used both English and Spanish. To close the gap on age range and educational level we created cards that were appropriate for a fourth grade level of education and teen cards. To handle different ethnicity, peer counselors are chosen to represent the ethnicity of the at-risk group attending. We needed to have give away prizes to create interest in our game, and we did this by getting donations from various company's such as Lamaze. We give away informational videos, magazines, soaps, coloring books and crayons, diapers and more in return for answering a game card correctly. We also purchased outreach items such as crayon boxes and snack containers that could be imprinted with a breast-feeding message and/or the WIC appointment hotline.

Funding Source: Other Federal
Description of other sources: WIC Program Funds
Budget: $120,000.00

Role of Health Department:

The health department WIC program staff planned and implemented the "WIC Makes breast-feeding Easy" outreach activity.

Accomplishments:

1. Targeted performance indicators have improved.
2. Hospital partners are very enthusiastic; hospital staff on postpartum floors are more supportive of breast-feeding promotion and WIC program referrals.
3. Improved communications between medical professionals and WIC.
4. Created a partnership with health insurance companies.

Lessons Learned:

We have learned it takes a community to make change and one organization alone cannot change societal views, as well as a group.

Minority Health Assessment Project

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Replicated: Yes
Evaluated: No

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Essential MCH Functions:	MCH Initiatives
Family planning Low birthweight/infant mortality Teen pregnancy Overcoming cultural barriers Strategic planning	Prepare, publish & distribute reports Public advocacy for legislation & resources Special studies

Description

Within the Minority Health Assessment Project report, we did an immigrant health report and an analysis of little reports being done. We looked at data sources and held community forums. The Advisory Committee looked at the reports, giving meaning to the recommendations.

Objectives

1. To complete a local assessment across the metro area.
2. To convene metro advisory committee.
3. To incorporate recommendations into Community Health Services planning.

Barriers Encountered

Our project attended a meeting with people all over the state of Minnesota. People were concerned about keeping the advisory committees engaged after the report was completed. It was a challenge to make it a metro-wide project and keep agencies interested. There are limited data sources that include race.

Strategies to Overcome

There were a good number of efforts to personally contact participants, some additional people were invited to the advisory committee. We used the local public health agencies as a secondary place for regular briefings and materials distribution so they would stay involved. We are working with Minnesota Department of Health in the implementation of the recommendations.

Funding Source: State
Budget: $219,000.00

Role of Health Department:

The health department has been the fiscal agent and lead agency on the research project. The department provided the majority of the staffing and oversight of a consultant. An advisory committee was created from nine local public health agencies. We met with the local Public Health Association regarding their experiences with new arrivals and with agencies' capacity. There were focus groups on new arrivals. A staff person went to English as a Second Language class.

Accomplishments:

The press release was picked up in the Nations' Health and agencies across the country have picked up the report. A press conference was held drawing attention to disparities with two reports "Closing the Gap" and "Social and Economic Conditions." The media and the minority press covered the press conference. We participated in two radio interviews. A staff person created a presentation of slides to each local unit of government to use for boards and city councils.

Lessons Learned:
Our ethnic specific data is limited to vital records data. We don't have enough data on populations of color and so we have to intentionally over-sample. Communities want action not simply more research. Communities want to get busy with the work at hand. We learned that the reports on Minority Health and Social Conditions were very similar. We are seeing more synergy on what is happening.

Osteoporosis Prevention and Screening

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Replicated: Don't Know
Evaluated: Don't Know

Essential MCH Functions:

- Breastfeeding/nutrition/WIC
- School-linked/based services
- Adolescent school-linked/based services
- Expanding private sector links
- Clergy & health connections
- Schools & health connections
- Staff training
- Building coalitions & partnerships

MCH Initiatives

- Community perceptions of health problems/needs
- Culturally appropriate health education materials/programs
- Assessment of provider reports regarding process and outcomes
- Prepare, publish & distribute reports
- Development of models
- Promote compatible, integrated services system initiatives
- Provide infrastructure/capacity for MCH functions
- Staff training
- Provide outreach services
- Identify high-risk/hard-to-reach populations & methods to serve them
- Identify & report access barriers

Description

Missoula County's Osteoporosis Prevention and Screening Program involved the design, development, and implementation of a community-wide public health intervention, focusing on osteoporosis. This wellness program concentrates on prevention, early detection, education, and medical follow-up of those at risk for this chronic disease, as well as early education through grade schools, high schools and universities.

Objectives

1. Decrease short- and long-term risk of hip and spine fracture for Missoula residents through development and delivery of community-wide osteoporosis prevention program.
2. Teach the younger population ways to improve bone mass before age 30.
3. Provide increased screening opportunities for the under-served and "at-risk" populations with emphasis on the homebound elderly, seniors receiving services at Missoula Aging Services and Missoula senior center. Native Americans, chronic tobacco and/or alcohol users, women, and Partnership Health Center patients.
4. Provide health care professional education on health advances in prevention, diagnosis, and treatment of the disease.
5. Form partnerships with community organizations including various service organizations, Partnership Health Center, Planned Parenthood and physician offices to support an ongoing effort to increase bone health and osteoporosis awareness in target populations (e.g. work with churches, service organizations to host educational sessions on osteoporosis and home health).

Barriers Encountered

1. Lack of understanding by medical providers of the importance of addressing osteoporosis prevention as part of routine medical exams for women, as well as men.
2. Turf issues from some medical providers.
3. Ongoing funding.
4. Skepticism about validity of peripheral ultrasound bone density testing.

Strategies to Overcome

1. Developing the skills of those involved with testing, counseling and explaining results to clients.
2. Providing regular education materials through mailings, as well as phone follow-up with health care providers whose patients had low scores.
3. Importance of presenting information on patient assistance programs, so those without insurance coverage for medications aren't deterred from participating.
4. Importance of teaching fall prevention in elderly, since reductions in fracture risk can take over a year of continuous medication use, exercise and dietary change.

Funding Source: Local Government
Description of other sources: Chutney Foundation Grant Partnership, Partnership Health Center Contract, fees for service
Budget: $43,000.00

Role of Health Department:
Leadership role in organizing program, developing partnerships, securing start-up funds, and delivering services.

Accomplishments:
1. Provided group education services to 400 Missoula area students (elementary-university).
2. Provided bone density testing, counseling and referral services to more than 2600 residents.
3. Delivered educational materials from the National Osteoporosis Foundation to 192 physicians.
4. Formed agreements with our Family and Community Health Center, numerous worksites, schools, and multiple nonprofit and/or governmental organizations for delivery of education and bone density testing services.
5. Delivered osteoporosis education to health professionals statewide through lectures and demonstrations and annual meetings for nurses, dietitians, public health professionals, gerontologists and home economist organizations.
6. Screening numbers are consistent with findings published by the National Osteoporosis Foundation.

Lessons Learned:
The most important first step in building a wellness or disease specific prevention program is developing public awareness that the disease is preventable and treatable. Building community awareness about a particular chronic disease, in this instance, osteoporosis, and that it is preventable and treatable, makes it more likely that people will come forth for services. If they think, "nothing can be done about it anyway," they won't try.

Alabama Baby Coalition

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Replicated: Yes
Evaluated: Yes

Essential MCH Functions:	MCH Initiatives
Low birthweight/infant mortality	none

Description

Mobile County's Alabama Baby Coalition (ABC) is a fetal and infant mortality review (FIMR) program established in 1999. The Coalition is composed of four teams. The information sharing team is responsible for designing confidentiality agreements and establishing MCUs with local hospitals, as well as developing medical records review forms that adhere to ABC's approved guidelines. The case review team examines individual case summaries, looks for opportunities for improvement, and makes recommendations to the community action team. The community action team identifies the public health care providers, consumer advocacy groups, human service providers, key local and regional community leaders, private health care providers, and other change agents who can influence the local health care delivery system and bring about needed improvements. The data collection team determines the Coalition's information needs and is developing an encoding tool to protect case anonymity.

ABC reviews all fetal deaths that occur at or after 20 weeks gestation and infant deaths under one year of age that are not suspicious or unexpected. This focused review of pertinent medical information provides the foundation upon which to build a better understanding of the underlying causes of Mobile County's fetal and infant mortality rates. It also provides a starting point from which to evaluate the performance of the community's health care delivery system and helps identify those actions critical to reducing preventable fetal and infant deaths in Mobile County.

Objectives

The program's primary mission is to lower Mobile County's fetal and infant mortality rates. A corollary mission is to determine the adequacy of local health care resources and make recommendations for improvements. The specific measurable objectives of this program are:

1. Abstraction of 50 percent of total cases during the reporting period.
2. Case review of 32 percent of total infant mortality cases.
3. Completion of 10 percent of maternal interviews.
4. Institution of action on 55 percent of FIMR.

Barriers Encountered

Three potential barriers to establishing the ABC were:

1. Determining the appropriate program structure.
2. Uncertainty as to how to implement the program and establish community consensus.
3. Assuring the smooth flow of information while maintaining strict confidentiality for hospitals, physicians, patients, and families.

Strategies to Overcome

1. The Coalition held a one-day conference in which directors of three established state FIMR programs presented their program features as potential modes for ABC.
2. The Coalition established MCUs between the Mobile County Health Department (MCHD) and four local hospitals. To establish consensus, appropriate stakeholders were invited to assume key leadership positions in the Coalition.
3. Mechanism to preserve confidentiality has been implemented whereby all identifiers are stripped and cases are assigned numbers. In addition, there has been extensive coordination to promote information flow between participating agencies.

Funding Source: Other Federal
Description of other sources: Alabama State Perinatal Advisory Committee
Budget: $50,000.00

Role of Health Department:

The MCHD was instrumental in providing funding and personnel to oversee the program and assist in its development. In addition, the MCHD provides quarterly and annual reports to the state and the community.

Accomplishments:

1. During the period January 2000 through June 2001, reviewed 100 percent of applicable cases and made appropriate referrals and recommendations.
2. Reinstated case management for SOBRA Medicaid patients.
3. Established a new substance abuse program called" Clean Start" designed to counteract this major cause of fetal and infant mortality and morbidity. A directory has been developed that identifies all local treatment facilities and provides explanations of the types of programs offered (inpatient, outpatient and residential) and insurance/payment method accepted. The directory has been given to all providers in the county to assist them in making appropriate referrals.
4. Designed, published, and distributed the Alabama Baby Coalition information brochure that explains the program's purpose and structure.
5. By mayoral proclamation, established the second week in November as Fetal and Infant Mortality Awareness Week. This event enjoyed full media coverage.
6. Improved bereavement services to mothers and families. A local grief support program, funeral home, and cemetery, with the agreement of local hospitals, is providing internment of fetal and infant remains for families who request these services. The funeral home is providing a monument titled "Baby Rest," granite markers, and plots that will accommodate 12 years of burials.

Lessons Learned:

1. Action must be taken early to establish smooth information flow between the participating agencies.
2. In the same way, actions to establish early community consensus are critical to the attainment of the program's goal and objectives.

Teen Life Challenge

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Replicated: Don't Know
Evaluated: Yes

Essential MCH Functions:	MCH Initiatives
Family planning Teen pregnancy Expanding private sector links Clergy & health connections Increasing social support Securing MCH assistance Building coalitions & partnerships	Provide infrastructure/capacity for MCH functions

Description

The Maternal Child Adolescent Health Project conducted a task force addressing teen pregnancy in Stanislaus County focused on determining the community's perceptions, the impact of media, the availability of services and activities for teens, teens' and parents' perceptions about the reasons for teen pregnancy, the best received teen pregnancy prevention education sources and incentives to pursue higher education.

The process resulted in the West Modesto King Kennedy Neighborhood Collaborative acknowledging a concern about teen pregnancy and offering to serve as a pilot site. With the Stanislaus County Health Services Agency and the Center for Human Services, this Collaborative wrote a proposal to the California Wellness Foundation for its Teen Pregnancy Prevention Initiative. A grant was awarded to this community driven project aimed at devising strategies to address the issue of teen pregnancy as an adult problem. The Maternal Child Health Director and the Director of California Rural Legal Assistance serve as the fiscal agents and administrative advisors for the project. Community members serve as administrative staff, volunteers, executive board and advisory committee. The Collaborative has successfully engaged the community, faith-based organizations, businesses, health care, city and county organizations/government, community-based groups, schools and parents.

Objectives

1. Increase condom distribution sites in the target area, use media and peer education to increase access to contraceptives and use of family planning, and decrease pregnancy.
2. Sex education attached to other venues such as sports clinics and events to increase male involvement, and awareness of condom sites and FP services.
3. Train 16 peer educators to provide education and information through workshops, TV broadcasts, and condom distribution at community events to increase knowledge of contraception, family planning services, statistical teen birth rates, youth resources, healthy teen sexuality, consequences of teen pregnancy, cost and health risks, healthy relationships, communicating with partners and parents, and peer pressure.
4. Partner with the Health Services Agency and the Women's Auxiliary to sponsor Girls' Group to involve girls in a variety of activities designed to broaden their life experiences, increase their knowledge of birth control and family planning, and career possibilities, and increase the use of contraception.
5. Continue to partner with the Healthy Start Neighborhood Outreach Workers (N.O.W.) to provide outreach within the community and train at least six ethnically and culturally diverse adults in sex education, to increase communication between adults and teens, knowledge of Teen Life Challenge (TLC) resources and activities, comfort in talking about sex, participation in TLC activities, and awareness pregnancy prevention activities.
6. TLC will work with the faith community to enlist adults to work with youth inside and outside their youth activities and denomination to increase the number of faith-based adults who communicate with teens about sexuality and who feel comfortable talking about ways to reduce teen pregnancy.
7. Establish and maintain alliances with decision-makers to influence educational curriculum, delivery of services, and youth activities. Partner with the local agencies to increase resources to further TLC's goal to reduce teen pregnancy, increase availability of contraceptive and family planning resources, and improved services to teens.

Barriers Encountered

Determining who actually led the project. Billed as a community driven project, the expectation from funders was that the fiscal agent would serve as the lead although the community had actually applied for the grant and solicited support for a fiscal agent (the County could not serve in this capacity).

Identifying and hiring appropriately skilled staff, while recognizing the project is time limited.

Balancing the involvement of the faith community (which was requested by the various community groups) and the involvement of other potential partners, i.e., Planned Parenthood.

Ensuring that activities become institutionalized as organizations face fiscal constraints.

Strategies to Overcome

Allowing the West Modesto King Kennedy Collaborative to serve as the lead in determining how the agencies can better partner has provided direction for the project. Partners agree that the focus has to stay on the community. The Collaborative initially decided that all employees for the project would be community members who had been volunteering at least 12-18 months to provide jobs for dedicated community members without jobs. As the project became more complex, it required more skilled staff to meet the objective.

Qualified collaborative staff were hired and have engaged agencies to provide education to the faith community. Staff plans to discuss the potential involvement of Planned Parenthood as partners to provide condoms to the distribution sites with the faith community.

The Collaborative partnered with the Health Services Agency/Public Health Services to determine what support services can be institutionalized and develop policy to ensure continued involvement. Collaborative members have developed subcommittees to deal with city/county and school involvement within the community.

Funding Source: MCH block grant
Description of other sources: Private, The California Wellness Foundation
Budget: $0.00

Role of Health Department:

The Stanislaus County Health Services Agency/Public Health Services was instrumental in assessing the issue of teen pregnancy in the County and in specific communities. The Agency serves in many capacities with community partners: administrative support, project director, outreach team, and assists with cultural and language specific education and information. Staff participate in assessing, planning, implementation and evaluation of activities. Staff serve as meeting facilitators, provide conference space, assist with writing proposals and reviewing reports, handling conflict, provide education and information to both collaborative staff and community members.

The epidemiologist assists with GIS mapping of teen pregnancy and other health concerns within the community.

Accomplishments:

Engagement of 16 members representing various faith-based organizations. Involvement of multiple partners; city and county, Health Services Agency, Modesto City Schools, local businesses, and Golden Valley Health Services Agency to provide a Teen Friendly Clinic. The Health Services Agency along with 11 other agencies are building a new center in West Modesto to provide "one stop shopping" a clinic, to include teen friendly health services, library literacy, community services agency, to provide access to Medi-Cal and Welfare services, police, probation, jobs, mental health services, etc. Involvement of the community in planning and implementing activities. Condom distribution sites providing accessible and friendly services to teens.

Lessons Learned:

The community knows what will and will not work for them. Agencies can provide a better service if the community is involved in the planning, decision-making and implementation. This kind of partnering takes time, but the outcome is much more rewarding for both. Teens want parents as their sex educators, but don't know how to ask. Parents prefer to provide education to their teens, but do not feel knowledgeable enough to do so. Almost every ethnic group wants the faith community more involved in discussing these issues with teens, yet many of them are also not as knowledgeable or comfortable with the subject. Teen pregnancy is not the problem, but rather a symptom of what's not being provided to teens in the homes, schools, churches, and throughout the community. Teen pregnancy is everyone's concern and no agency or community can address this issue alone.

Fairy Dust and Flossing Lessons

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Replicated: Don't Know
Evaluated: No

Essential MCH Functions:	**MCH Initiatives**
Early intervention/zero to three Dental programs Schools & health connections	Culturally appropriate health education materials/programs Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services

Description

Dressed in a flashy formal gown with a magic wand, I introduce myself as one of the many "Tooth Fairies" whose wings only come out "when the sun goes down." I read from and show the children a large format book that covers aspects surrounding good oral hygiene and nutrition. A puppet named "Allie" the alligator helps to demonstrate brushing and safety habits like not playing with toys in your mouth, as well as telling the truth all the time. I dress several children from the audience in costumes I designed and made, to be teeth and a tongue. Demonstrating with a four foot long toothbrush and piece of rope, I show how and where to brush and floss the plaque away, how cavities form, and how to avoid cancer of the tongue by not smoking.

Objectives

The children should be able to tell me that they should:
1. Brush three times every day.
2. Brush softly in circles and tickle the gums.
3. Brush their tongues.
4. Floss daily with parent's help.
4. Eat healthy snacks and avoid junk foods.
5. See the dentist if a cavity is found or a tooth hurts.
6. Play nicely and watch to avoid accidents
7. The "Tooth Fairy" is REAL!

Barriers Encountered

The physical space in schools and day care centers to gather the children for a program is limited. The presentation works best with a group of 60 to 120. Communication with teachers to set up programs is a challenge because they do not all have phones in their rooms and it's difficult to call them away from their classrooms.

Strategies to Overcome

Teachers are anxious to have this program presented to their students because it is age appropriate and entertaining. They work together with their school to schedule times after breakfast, before and after lunch in their cafeterias. Sometimes a teacher will rearrange a classroom to accommodate several classes. Hallways are utilized and occasionally, weather permitting, I perform outside. To help remedy the communication problems the health department supplied me with a cell phone.

Funding Source: Local Government
Budget: $52,000.00

Role of Health Department:

1. Understanding the need for oral health education.
2. Providing the flexibility to develop and present this program.
3. Funding for toothbrushes and handouts to help teachers reinforce this lesson.

4. Technical assistance in designing and printing handouts.
5. Opens doors of schools, libraries and day-care centers for programs because of a respectable reputation of the health department.

Accomplishments:
Provide education programs for 10,000 children yearly.
Build children's self esteem by presenting information needed to care for their teeth.
Break down cultural barriers, everyone has teeth and even non-English speaking children are entertained.
Provide a positive attitude toward teeth and teeth care.
Learning through interaction.

Lessons Learned:
Children enjoy learning in an interactive format. It takes practice to keep their attention focused and for them to let me tell the story. This age group all have a story to tell and effectively maintaining center stage with them is a challenge even for the "Tooth Fairy." They never wanted to leave when the program was over, so "Allie" allows them to pet him on the head as they leave. I have learned that the impact of this program is very long lasting because children recognize me as the "Tooth Fairy" years later-out of costume.

MCH Program Integration

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Replicated: No
Evaluated: No

Essential MCH Functions:

- Prenatal care
- Home visiting
- Low birthweight/infant mortality
- Immunizations
- Teen pregnancy
- Teen parenting
- Overcoming cultural barriers
- Case coordination
- Increasing access to Medicaid
- Staff training
- Reshaping urban MCH
- Building coalitions & partnerships
- Building MCH data capacity

MCH Initiatives

- Maternal, fetal/infant, child death reviews
- Hotlines, print materials, media campaigns
- Culturally appropriate health education materials/programs
- Prepare, publish & distribute reports
- Promote compatible, integrated services system initiatives
- Provide outreach services
- Referral systems, resource directories, advertising, enrollment assistance
- Identify high-risk/hard-to-reach populations & methods to serve them
- Provide, arrange, administer direct services

Description

Integrating the core programs of the MCH Division into a citywide system of service delivery that includes care coordination and client identification, while standardizing and implementing a fully integrated system of data collection and program evaluation.

Care Coordination:

New Haven Healthy Start team of four care coordinators at the two New Haven hospitals and two federally qualified health centers will assess risk of pregnant women presenting for PNCs, twice during the prenatal period (including a postpartum depression screen), develop care plans for those identified "at-risk," and coordinate care between the site and the health department through a system of care management.

Client Identification:

1. HUSKY (statewide SCHIP and Medicaid programs). Application assistance for uninsured and underinsured pregnant women and children.
2. New Haven Healthy Start Initiative – community outreach workers will focus outreach and capacity building efforts, beginning with the preconception period throughout the entire prenatal and postpartum periods up to two years focusing on women of child bearing age utilizing shelter and treatment facilities, teen pregnancy/parenting programs and truancy, and Latina and undocumented pregnant and parenting women.
3. Pediatric Immunization Unit provides immunization registry and outreach to families whose children who are under immunized by 24 months.

Case Management:

MANOS (Maternal and Newborn Outreach Support) intensive family support and home visiting program connects pregnant women, infants and children with health care and referrals to community-based organizations.

Data Entry:

New Haven Healthy Start/Health Department clients will be entered from client identification and care management programs (HUSKY, MANOS, Pediatric Immunization Unit and the New Haven Healthy Start programs) into one database.

Objectives

1. Pregnant women outside of care will be identified (HUSKY, NHHS) and referred for PNC.
2. Pregnant women receiving prenatal care will be assessed for risk by the care coordinators, using a universal risk screening tool, developed by the New Haven Healthy Start program evaluators, twice during the prenatal period and one time during the postpartum period.
3. Pregnant women will be screened for postpartum depression.

4. Pregnant women identified "at-risk" will receive care coordination including risk assessment, care planning, referral and follow-up and a referral to the MCH Division's MANOS program.
5. The client identification, care coordination and case management programs will be fully integrated utilizing a standardized registration form from which data will be collected and disseminated by the care coordination and case management team and program evaluators and planners.

Barriers Encountered

1. Institutionalized resistance to "system change."
2. Institutionalized resistance to service integration.
3. Institutionalized resistance to data collection.

Strategies to Overcome

We have developed a Perinatal Partnership which is comprised of clinicians, public health professionals and community-based organizations whose mission is to address the delivery of health services and improve birth outcomes across systems. This partnership is a subcommittee of our Healthy Start Consortia and chaired by an obstetrician and pediatrician.

Creating a fully integrated database which can be utilized by the Perinatal Partnership for program planning, grant making and system change.

Funding Source: Local Government
Description of other sources: State, MCH block
Budget: $1,300,000.00

Role of Health Department:

The health department's MCH division is part of a federal Healthy Start management team that includes the health department's MCH Director, the Women's Health Director and the Community Foundation for Greater New Haven's Health Program Officer and the New Haven Healthy Start's Project Administrator. The management team is responsible for the successful integration of the goals and objectives of the New Haven Healthy Start Initiative, with the health department's MCH division core programs fully integrated. Beginning July 1, 2001 the success of the MCH program integration will be evaluated by Yale University School of Public Health and Epidemiology.

Accomplishments:

Received federal Healthy Start funding for disparities in birth outcomes, interconceptional care and postpartum depression screening.

This funding has allowed the health department to move forward with our care coordination/service integration model and the community providers to move forward with a fully integrated system of care coordination and data collection.

Lessons Learned:

Too soon to say, but we are hopeful that in this first phase we can enhance communication among all of the providers and move toward a fully integrated system of care that identifies women most in need and provides a system of care connecting them with services to improve birth outcomes.

Health Rangers Advocate Program

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Replicated: Don't Know
Evaluated: No

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Essential MCH Functions:

- Family planning
- Breast/cervical cancer
- Low birthweight/infant mortality
- Substance abuse prevention
- Breastfeeding/nutrition/WIC
- Injury (including child abuse)
- Lead poisoning
- Children with special needs
- Violence prevention/at risk
- Teen pregnancy
- Communicable diseases
- Overcoming cultural barriers
- Clergy & health connections
- Schools & health connections
- Other outreach activities
- Increasing social support
- Staff training
- Strategic planning
- Securing MCH assistance
- Building coalitions & partnerships
- Building MCH data capacity

MCH Initiatives

- Community perceptions of health problems/needs
- Environmental assessments
- Hotlines, print materials, media campaigns
- Culturally appropriate health education materials/programs
- Implement/support education services for special MCH problems
- Development of models
- Provide infrastructure/capacity for MCH functions
- Staff training
- Support of continuing education
- Referral systems, resource directories, advertising, enrollment assistance
- Monitor enrollment practices for ease of use
- Identify high-risk/hard-to-reach populations & methods to serve them
- Identify & report access barriers

Description

It was the concept of the Newark Department of Health and Human Services (NDHHS) to recruit community volunteers throughout the city as "health rangers." After an extensive orientation covering an overview of health issues and resources in the city, each ranger was encouraged to develop a project. A photo ID, certificate of graduation, and access to literature for distribution and technical assistance was issued at the end of the orientation. Projects included weight control, environmental health, immunization, date rape reduction, teen pregnancy, decreasing the incidence of HIV and STD, asthma, smoking cessation, and more efficient access to health care.

Objectives

To spread health information and to increase health awareness, including available services, within the city. To develop a more visible and positive presence for NDHHS. To form partnerships with the community to combat health ills. To track:

1. Amount of information distributed.
2. Number of people contacted.
3. Number/kind of referrals made.
4. Anecdotal feedback from participants.

Barriers Encountered

1. Time commitments from participants and technical support.
2. Lack of funding.

Strategies to Overcome

1. Searching for additional funding sources to cover resource materials, program expenses, and supplies.
2. A new health educator has been hired with this activity as a major task.

Funding Source: Local Government
Budget: $5,000.00

Role of Health Department:
The NDHHS is the lead agency responsible for the training and coordination of the program.
The NDHHS provides technical assistance to rangers, as well as resource materials and ongoing monitoring.

Accomplishments:
1. Formation of coalitions with major community players such as hospitals, churches, day care centers, political leaders, and community-based organizations.
2. Promotion of the health department as an advocate for improving the health of the community.
3. Recruiting community members to become involved in solving community health problems.

Lessons Learned:
There are a lot of resources in the form of voluntary manpower who are willing with guidance, to give back to the community and to help keep it viable.

Bullying Prevention Program

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Replicated: Don't Know
Evaluated: No

Essential MCH Functions:	**MCH Initiatives**
School-linked/based services	Community perceptions of health problems/needs
Adolescent school-linked/based services	Hotlines, print materials, media campaigns
Violence prevention/at risk	Prepare, publish & distribute reports
Family violence	Special studies
Schools & health connections	Promote compatible, integrated services system initiatives
Increasing social support	Staff training
Case coordination	Support of continuing education
Staff training	Provide outreach services
Strategic planning	Referral systems, resource directories, advertising, enrollment assistance
Building coalitions & partnerships	

Description

The Bullying Prevention Program, a component of the Safe Schools/Healthy Students Initiative, is part of a comprehensive effort to ensure that our schools are safe places for all who enter. The program is a whole-school program, involving students, staff, and parents in Norfolk and Portsmouth public schools, in addressing the issue of bullying, which has frequently been identified as a precursor to incidences of school violence. The program is designed to change the school climate, as well as change peer attitudes regarding the issue of bullying.

Objectives

1. To decrease the prevalence of bullying in targeted Norfolk and Portsmouth public schools 15-20 percent by October 2002, as evidenced by SMART data and data obtained from bullying surveys.
2. To increase staff awareness and knowledge of the issue of bullying, as measured by bullying survey data.
3. To increase community and parental awareness and knowledge of the issue of bullying.
4. To increase student awareness and knowledge of the issue of bullying, as measured by data obtained from bullying surveys.
5. To identify children with bullying behaviors and children who are targets of bullies through development of a tracking system.
6. To offer interventions and strategies for working with bullies and targets of bullies.

Barriers Encountered

1. Refusal on the part of some school administrators and staff, to acknowledge that bullying is either an issue of concern, or an issue for their particular school.
2. Difficulty coordinating efforts with two school systems, the health department, and Old Dominion University, which is providing evaluation analysis.

Strategies to Overcome

1. Education and utilization of survey data to pinpoint areas of concern for specific schools.
2. Frequent and thorough communication and meetings with all involved agencies' representatives.

Funding Source: Other Federal
Budget: $76,000.00

Role of Health Department:

The Norfolk Department of Public Health has provided planning and implementation of the program through services of a Bullying Prevention Program Coordinator. Additionally, the NDPH maintains a resource lending library for all schools involved in the program and provides consultation services to involved schools. The NDPH is the lead agency for the Bullying Prevention Program.

Accomplishments:
Involvement of eighteen Norfolk and eight Portsmouth public schools during the initial year of the program, with all elementary and middle schools in both cities, with the exception of two schools in Portsmouth and three schools in Norfolk, coming aboard to participate during the second year.
Development of a "Stop Bullying" brochure for parents, that has been widely distributed in the cities, and has received national attention.
Successful completion of a two-day conference on the issue of bullying.

Lessons Learned:
There is much interest and a great need for knowledge concerning the issue of bullying, as well as much resistance to viewing bullying as a significant area of concern.

The Information's In The Supplies

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Replicated: No
Evaluated: No

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Essential MCH Functions:	**MCH Initiatives**
Schools & health connections Building coalitions & partnerships	Hotlines, print materials, media campaigns Newsletters, convening focus groups, advisory committees, networks

Description

The Oklahoma City-County Health Department, in partnership with the Oklahoma Institute for Child Advocacy, conducted focus groups with area high school students on health related issues. In response to the information gathered from these focus groups, health related information was printed onto dividers and placed into binders to be given to high school suppliers. Printing health information on needed materials increases the chances that it will be read and accessible. The students at the high school assisted in the development and format of the printed materials.

Objectives

1. Hear teens' specific health concerns and unmet needs.
2. Identify nontraditional factors influencing the overall health of teens.
3. Provide health-related information to teens in a format that they would read and keep throughout the year.
4. Provide teens with basic health statistics about their peer group in a language they can identify with and find interesting.

Barriers Encountered

1. Encouraging school participation to identify students to participate in focus groups.
2. Working within the student's school and work schedules.
3. Having access to student input during the summer break.

Strategies to Overcome

1. By frequent and repeated contact with the schools, students were identified for the focus groups from most schools.
2. By working through individual teachers and principals, students were identified to assist in the development of the health education materials, which continued through the summer months.

Funding Source: Other Federal
Budget: $24,000.00

Role of Health Department:

The Oklahoma City-County Health Department (OCCHD) subcontracted with the Institute for Child Advocacy to develop health education materials for teens. (The HEART of OKC, a teen pregnancy prevention project of the Institute for Child Advocacy, is funded through a grant from the CDC). OCCHD convened teen focus groups, developed the format and the information to be presented, and worked with high school students in the development and production of the materials.

Accomplishments:

By using the approach of combining needed health information and school supplies, the likelihood that the students will keep the health information provided and read it throughout the year is increased. OCCHD is currently in the process of producing the binders for distribution at the beginning of the 2001-2002 school year.

Lessons Learned:

Structure the project's timelines to accommodate the school's calendar and student availability.

Ask teens what is missing from health education. Many nontraditional issues mentioned by teens can have a direct impact on their health and their attitudes toward health. Address these issues in the information you provide.

Find out what teens need or want and work to present information in that format, if possible.

WIC and Early Intervention Services Integration Program

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Replicated: No
Evaluated: No

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Essential MCH Functions:	**MCH Initiatives**
Breastfeeding/nutrition/WIC Children with special needs Reducing transportation barriers Schools & health connections Staff training Building coalitions & partnerships	Implement/support education services for special MCH problems Staff training Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them

Description

In the summer of 1999 WIC and the three Early Intervention Services agencies in the Omaha metropolitan area met to develop a plan to improve both the early identification of children with special needs and their access to nutritional services. The group developed two initiatives, a developmental screening tool for use in WIC clinics and a facilitated WIC enrollment process for medically fragile children. The screening conducted by the WIC nurse evaluates infants and children at ages 6, 12, 18, 24 and 36 months via the use of three simple questions or observations at each age category. When a child is identified as at risk for developmental delays, staff informs parents of the early intervention services and completes a referral for those services. Medically fragile children are referred to the WIC program by early intervention staff via use of a facilitated enrollment tool. This tool allows Early Intervention Service Coordinators to obtain relevant enrollment data such as anthropometric data, medical diagnosis, formula prescription, income data and immunization records. The WIC Nutrition Coordinator completes the enrollment process by phone or as a home visit and conducts nutritional assessment and counseling. Any additional medical data is obtained through a fax from the child's medical provider. Voucher distribution is determined to meet family need, i.e., at clinic , via U.S. mail or home delivery.

Objectives

1. Increase the number of children identified for Early Intervention Services in WIC by at least 50 children per year.
2. To enroll at least 20 medically fragile children per year into WIC services who would have not been able to receive services due to risk of illness or injury.
3. Improve the nutritional status of medically fragile children through improved access to needed nutritional services and communication with medical providers.

Barriers Encountered

1. State program regulations, which limited innovative off-site enrollment in the WIC program.
2. WIC staff apathy to utilize the screening tool and make the referral for Early Intervention Services.
3. Development of acceptable screening and enrollment tools to meet the needs of all three Early Intervention Programs and multiple school districts.
4. Development of the communication networks with the wide range of area medical providers.
5. Limited staff experience with special needs children's nutritional concerns and interventions.

Strategies to Overcome

1. Involving the state WIC office staff in all phases of program planning to allow for acceptable compromise and clarification in both program and form development.
2. Training WIC staff regarding developmental milestones and the Early Intervention Services along with constant and varied communication between WIC and Early Intervention staff to share successes and perceptions.
3. Utilizing a small but representative work group with a shared vision and mission to develop the program.
4. Utilizing the local medical society to inform area medical providers of the project and their contribution.

5. Training of the Nutrition Coordinator by area pediatric dietitians regarding feeding and nutritional management.

Funding Source: Other Federal
Budget: $0.00

Role of Health Department:
The health department housed the WIC program and was therefore the instrumental in convening the initial meeting, establishing the models of integration and implementing the program.

Accomplishments:
1. 28 medically fragile have been served through the program since its inception with a current clinic census of 17.
2. An average of three to five children are referred each month to Early Intervention Services.
3. Improved nutrition education and management of children with special health care needs via improved communication between medical providers and the WIC program.

Lessons Learned:
1. Through a shared outreach, children with special needs can be identified early for both educational and nutrition services.
2. Programs which emphasize facilitated access or screening require both intensive staff training and ongoing staff commitment to be successful.
3. Ongoing communication with partner agencies is essential to assure participation.
4. If the target population is narrowly focused and well defined, a shared vision and mission is more easily identified.

Targeted Intensive Prenatal Case Management (TIPCM)

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Replicated: No
Evaluated: Yes

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Essential MCH Functions:	**MCH Initiatives**
Prenatal care Expanding maternity services Home visiting Low birthweight/infant mortality Teen pregnancy Interdisciplinary team model of enhanced case management. Positive reinforcement techniques are utilized to support clients' development of pro-social prenatal behavior. Marketing strategy targets the lay and professional community.	Hotlines, print materials, media campaigns Prepare, publish & distribute reports Public advocacy for legislation & resources Development of models Newsletters, convening focus groups, advisory committees, networks Promote compatible, integrated services system initiatives Interdisciplinary team model of enhanced case management. Positive reinforcement techniques are utilized to support clients' development of pro-social prenatal behavior. Marketing strategy targets the lay and professional community.Identify high-risk/hard-to-reach populations & methods to serve them Identify alternative resources to expand system capacity

Description

TIPCM is a pilot project implemented in eight communities in the state of Illinois, specifically designed to reduce instances of infant mortality and low birthweight among high-risk pregnant women. The program's desired outcome is to decrease the number of pregnancies resulting in birthweight of 5.5 lbs. or less. The Peoria County model includes:

1. Interdisciplinary nurse/social worker case management teams.
2. Behavior modification/positive reinforcement methodology.
3. Increased frequency of client visiting (N=2xmonths).
4. Small/capped caseload size (N=40).
5. Media/marketing strategy targeting the lay and professional community.

Objectives

Enhance intervention strategies among the county's population of pregnant women at greatest risk of poor birth outcomes. Optimize fetal development through an enhanced case management model with these features:

1. Early identification and enrollment using defined medical/psych-soc-environmental risk criteria.
2. Frequent client contact through the pregnancy-i.e., twice monthly; one visit is in-home.
3. Capped caseloads at a maximum of 40 clients.
4. Interdisciplinary nurse/social worker case management team model.
5. Positive reinforcement incentive policy related to client attainment of specified goals.
6. Statewide uniformity in the evaluation of key indicators through a computerized data entry system.
7. Inter-agency collaboration to cross-refer high-risk pregnant clients.

Barriers Encountered

1. Hiring/reassigning academically qualified nursing and social work staff to represent the interdisciplinary team.
2. Defining the TIPCM risk criteria.
3. Identifying and enrolling the pilot project's target number of pregnant women (N=192).
4. Developing strategy to promote client compliance with identified Care Plan goals.
5. Promoting inter-agency referrals of high-risk pregnant women from allied agencies and primary care providers. Focusing on "shared responsibility."
6. Marketing the TIPCM program within the lay community, resulting in self-referrals for enhanced case management services.

Strategies to Overcome

1. Developing a qualified interdisciplinary team--to develop a pilot site model.

2. Defining the TIPCM risk criteria--a preliminary set of risk criteria, identified by the Illinois Department of Human Services.
3. Identifying and enrolling the project's target number of pregnant women (N=192). Case load was reviewed; pregnant women meeting the risk criteria were identified. Case management staff were trained to identify qualified clients seen in pregnancy testing clinic. Referrals were secured from allied agencies in the community.
4. Developing an individualized strategy to promote client compliance with identified Care Plan goals--Behavior Modification theory was reviewed, noting that positive reinforcement promotes the development of pro-social behavior. Focus groups were conducted revealing client gratification related to receiving $10.00 Wal-Mart gift certificates. An incentive policy was developed that promotes and acknowledges compliant behavior, as well as the development of clients' self-confidence/esteem.
5. Promoting inter-agency referrals of high-risk pregnant women. Developed a marketing strategy to promote the TIPCM project within the professional community. A theme, "Just Ask What We Can Do For You!" was chosen to engage area professionals. Local agencies and primary care providers were invited to a breakfast meeting.
6. Marketing the TIPCM program within the lay community, with billboards, radio and TV spots encouraging pregnant women to contact the health department for services.

Funding Source: Local Government
Budget: $242,400.00

Role of Health Department:
The Peoria City/County Health Department planned the TIPCM program's implementation at the local level. The development of interdisciplinary teams, behavior modification methodology, and a two-pronged media/marketing campaign directed at the lay and professional community resulted. Local success and methodology has been shared with pilot site colleagues, and presented to the DHS staff at the state level. As evaluating data is collected, the agency's "best practices" will be identified and profiled for possible replication.

Accomplishments:
Following eight months of enhanced case management intervention with high-risk pregnant women, TIPCM accomplishments to date (as of 8/1/01) include:
1. Effective birth outcomes-82 percent of total births (N=61) = 5.5 lbs./or greater.
2. Implementation of behavior modification methodology.
3. Implementation of an interdisciplinary (BSN/MSW)/enhanced case management team/model of service delivery.
4. Implementation of a computerized local and state data collection system.
5. Effective media/marketing campaign targeting the lay and professional community.

Lessons Learned:
1. Frequent contact (N=2x/mo.) fosters early engagement and a trusting client-case manager rapport.
2. Frequent contact keeps assessments current and referrals timely.
3. Capped caseloads (N=40) promotes greater client/case manager familiarity, and the development of individualized/client-specific Care Plans.
4. An interdisciplinary team model (BSN/MSW) results in high-risk client assignment to "best fit" discipline, problem-solving complex cases per shared expertise, insight and recommendations, and minimizing staff burn-out via maximized team synergy.
5. Positive reinforcement/reward distribution increases client compliance, self-confidence, and the development of prosocial/responsible behavior.
6. A computerized system of data entry promotes uniformity in the state/local evaluation of key indicators; program-specific successes can thus be identified and replicated in subsequent models.
7. A two-pronged media/marketing campaign can be effectively designed to target both the lay and professional community.

Osteoporosis Screening Initiative

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Replicated: No
Evaluated: No

Essential MCH Functions:	MCH Initiatives
Overcoming cultural barriers Staff training prevention services for older women	Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Staff training Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services

Description

Background: Osteoporosis or osteopenia affects over 28 million Americans, putting them at risk for pain and fractures. Over 40 percent of women over the age of 50 will sustain a fracture. Of these women, up to 20 percent will die, 25 percent will be confined to a nursing home, and 50 percent will experience long-term loss of mobility. Spinal fractures can be associated with pain, loss of height, and deformities (Dowager hump). The annual cost of osteoporosis is estimated at $13.8 billion.

The Initiative: In response to the issues noted above, the Philadelphia Department of Public Health implemented a screening program to educate and treat health center patients for osteoporosis. Screening guidelines were provided to all health center physicians, nurse practitioners, clinical directors, and health care coordinators. The guidelines require providers to screen all patients over 50 for osteoporosis risk factors. Other activities: see Accomplishments.

Objectives

The initiative seeks to reduce the incidence of osteoporosis through enhanced screening in Philadelphia health centers. Health center providers were trained to screen for the following risk factors: thinness, history of fractures after age 50, either personally or in a first-degree relative, early surgical or natural menopause, frailty, use of oral steroids, alcoholism, physical inactivity, and white race. Providers are to measure the height of all women over 50; recommend adequate calcium in the diet, recommend Vitamin D, recommend weight-bearing, muscle-strengthening exercises, and (when necessary) order a DXA scan (dual energy x-ray absorptiometry) for evaluation of Bone Mineral Density (BMD). Patients in need of immediate treatment for osteoporosis receive extended education and treatment recommendations, including: exercise, calcium and Vitamin D, smoking cessation, limiting of alcohol, estrogen replacement therapy and biphosphonates. While osteoporosis is more common in white women than in African American women (33 percent and 25 percent, respectively), providers are required to screen all patients equally, in order to detect and prevent cases of osteoporosis that would otherwise remain undiscovered in the health centers' largely African American patient population. The impact of hip fracture is particularly devastating, because the rates of mortality and disability after fracture are higher among African American women than among white women.

Barriers Encountered

There was a learning curve among some providers regarding the importance of screening African American patients as closely as white patients.

Strategies to Overcome

Provider education conclusively removed any provider doubts.

Funding Source: Local Government
Budget: $3,000.00

Role of Health Department:

The Philadelphia Department of Public Health assumed full responsibility for planning and implementing this initiative, including training health center staff and providing educational materials. Materials included a comprehensive listing of foods from different ethnic cultures that contain calcium.

Accomplishments:

The primary accomplishment to date is improved screening for, and increased awareness of, osteoporosis. In addition, the comprehensive list of ethnic foods containing calcium has helped to make the issue of osteoporosis relevant to all of Philadelphia's diverse communities. The injury prevention division of the health department has hosted a series of exercise programs in recreation centers for adult women and children. The programs are designed to raise awareness about osteoporosis while demonstrating easy to follow preventive exercises.

Lessons Learned:

Provider education can lead to improved services for patients.

Obstetric Provider Visitation by Community Health Nurses

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Replicated: Don't Know
Evaluated: No

Essential MCH Functions:	**MCH Initiatives**
Prenatal care	Community perceptions of health problems/needs
Expanding maternity services	Environmental assessments
Low birthweight/infant mortality	Assessment of provider reports regarding process and outcomes
Teen pregnancy	Staff training
Overcoming cultural barriers	Provide outreach services
Expanding private sector links	Transportation & oter access-enabling services
Other outreach activities	Referral systems, resource directories, advertising, enrollment assistance

Description

Between April 11 and June 18, 2001 the Maricopa County Department of Public Health's (MCDPH) Community Health Nurses conducted resource presentations and focus group sessions with staff from ten obstetric provider offices that serve the Maryvale area, a community within Phoenix. All offices were offered a complimentary lunch for the entire staff for the nurse to orient them to this project including purpose and goals. They were also asked five predetermined questions and instructed that the results would be kept in confidence and would be published in aggregate form. A committee developed a community plan-based on needs identified. If resources become available, MCDPH will also develop an individualized plan for each office to address their needs in order to increase access to prenatal care and to be able to better address the social/environmental needs of their patients.

Objectives

1. Educate obstetric providers as to resources available to their clients.
2. Identify primary needs facing pregnant women and families served by the obstetric providers, and where these women are currently referred.
3. Increase number of referrals initiated by obstetric office staff.

Barriers Encountered

The Community Health Nurses were generally available to perform services only when other tasks were completed. While the nurses were enthusiastic about the project, they did have to manage their tasks among competing priorities.

Strategies to Overcome

A limited number of obstetric offices were selected for visitation. Each Community Health Nurse was requested to contact one office for visitation, and the supervisor was supportive of the project. In essence, the mission was narrow. The nurses viewed this project as a return to what first interested them in community health.

Funding Source: Local Government
Budget: $1,225.00

Role of Health Department:

The Maricopa County Department of Public Health was responsible for planning, organizing and providing the presentations.

Accomplishments:

1. OB Providers' perceptions of client needs were identified.
2. OB Providers' input into how the providers could be better supported was discussed.
3. Education of community resources was provided.

Lessons Learned:

1. All offices indicated that they had made at least a few referrals, however the total volume of referrals by most individual offices was not high. Most offices are only making referrals to a couple of agencies (not necessarily the same two).
2. Community Health Nurses must become more familiar with services offered for the needs identified to insure that OB Provider staff are well trained.
3. Needs are so extensive they must be met by numerous agencies.
4. The only way obstetrics offices will make referrals is if the process is simplified considerably from what is currently involved.

Child Death Review

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Replicated: Yes
Evaluated: No

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Essential MCH Functions:	MCH Initiatives
Building coalitions & partnerships Building MCH data capacity	Maternal, fetal/infant, child death reviews Implement/support education services for special MCH problems Prepare, publish & distribute reports Promote compatible, integrated services system initiatives

Description

A team of professionals conduct individual confidential case reviews of deceased children in Allegheny County. Team members include physicians from all major hospitals in Pittsburgh, police officers, health department staff, representatives from the child protection agency, the coroner's and district attorney's offices, the office of behavioral health and juvenile court, and traffic safety and injury prevention experts. All infant/child deaths from birth through age 19 are reviewed to determine if and how the death might have been prevented. All team members sign a confidentiality statement which defines conditions of participation.

Objectives

1. Enable our county to better identify the causes and manners of child deaths.
2. Share information between professionals and organizations involved in responding to child fatalities.
3. Enhanced operation between all professionals.
4. Develop and implement methods for preventing future child deaths.

Barriers Encountered

The greatest barrier initially was the lack of knowledge of members' roles and the lack of trust. The team meets monthly, so it took most of the first year for members to get acquainted and begin to share information openly and honestly. As we complete the third year, gaining consensus regarding appropriate action and implementing preventive activities are the most time consuming.

Strategies to Overcome

New members are briefed, if possible, prior to attending the first meeting where they are welcomed and introduced. They witness the trust and open discussion demonstrated by members and quickly become integrated with the team. The focus is always on prevention, not on placing blame or "finger pointing."
Special meetings may be convened to work on a specific issue (i.e., reviewing sudden unexpected infant death investigation procedures, planning presentations of findings to the public). More staff time is now devoted to carrying out team recommendations.

Funding Source: Local Government, MCH block grant funds
Budget: $40,000.00

Role of Health Department:

The department utilized the protocols provided by the Pennsylvania Chapter of the American Academy of Pediatrics for establishing child death review teams. This Chapter is funded by Pennsylvania Department of Health to work with leaders in each county to organize CDRTs. Our department convenes and chairs each meeting and staffs team activities. We also prepare and distribute the annual reports and provide leadership in carrying out many of the recommendations.

Accomplishments:
Communication between team members and the agencies they represent has improved. This carries over to situations not involving fatalities; members are now more likely to communicate with each other. The accuracy and completeness of death certificates is improved. This is attributed to a growing awareness by members of the problem and to training for physicians provided by the coroner's office. Police and emergency medical staff have been trained on appropriate management of the death scene with distraught parents and caregivers.
Services have improved in several areas. The coroner's office assigned a specific trained individual to investigate sudden unexplained infant deaths. Plans have begun to create a multidisciplinary team, including police, coroner and child protection, to investigate all unexpected, sudden infant and child deaths. Because smoking during pregnancy is a risk factor for infant mortality, a survey of local medical insurances was completed to identify covered smoking cessation programs. The department worked with special needs units of local Medicaid managed care organizations on follow-up for missed appointments and outreach for sick children. The reviews stimulated collaboration in the new projects including "cribs for kids" that provides cribs for low-income families.

Lessons Learned:
Although we had anticipated that some time would be required for team members to trust each other, that took longer than we expected. It is clear that having the right agencies and institutions "at the table" is critical, as is having representatives who come to team meetings regularly and participate freely. It's important not to underestimate the time required to implement team recommendations.

Student Health Centers

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Replicated: Don't Know
Evaluated: Don't Know

Essential MCH Functions:

- Immunizations
- EPSDT/screening
- School-linked/based services
- Adolescent school-linked/based services
- Teen pregnancy
- Schools & health connections
- Increasing access to Medicaid
- Strategic planning
- Reshaping urban MCH
- Building coalitions & partnerships

MCH Initiatives

- Community perceptions of health problems/needs
- Culturally appropriate health education materials/programs
- Public advocacy for legislation & resources
- Promote compatible, integrated services system initiatives
- MCH input in legislative base for health plans & standards
- MCH legislative activity
- Identify high-risk/hard-to-reach populations & methods to serve them
- Provide, arrange, administer direct services
- Managed Care model contracts & access issues
- Identify alternative resources to expand system capacity

Description

In August 2000, the Portland Public Health Division closed the doors of its neighborhood pediatric primary care clinics after over 20 years of delivering health care. Over a three-year period, our clinic caseload had fallen from over 700 children to a little over 300. This was actually good news because we knew this meant that families were finding it easier to get access to primary health care in our community. With the involvement of the entire clinic staff, we carefully looked at the gaps and needs that remained in our community relative to MCH and strategically developed a plan to open three new school-based health centers in addition to the three that already existed. A year later, with six sites operating we are back up to a total clinic caseload of over 700 and expectations for an increase in our numbers served next year.

Objectives

1. Provide access to health care for students at six school-based health centers.
2. Ensure that each of the enrolled students is also connected to a medical home.
3. For each enrolled student without insurance, assist the family to apply for CHIP coverage.
4. Bring all enrolled children up-to-date with required immunizations.
5. Ensure that all enrolled children are receiving health maintenance exams according to Bright Futures periodicity guidelines.

Barriers Encountered

1. Securing support from the school system.
2. Securing support from the health care community.
3. Forecasting sustainability over time.

Strategies to Overcome

1. Met and formulated plan with Superintendent School Committee, principals and school nurses.
2. Met and formulated plan with stakeholder groups of primary physicians, subspecialists and hospital clinics.
3. Ongoing discussions with Medicaid, initiated discussions with commercial insurers, lobbied and successfully secured an increase in statewide allocations to school-based health centers, successfully lobbied for financial support from partnering hospital.

Funding Source: Local Government, MCH block grant
Description of other sources: Third party reimbursement, Private sources: Grant from hospital, student fees
Budget: $475,250.00

Role of Health Department:
Portland Public Health Division has planned and implemented this program in partnership with the school system and the hospital and has the responsibility for the ongoing evaluation and management.

Accomplishments:
1. Over 700 school age children receiving health care.
2. Recognized as a model in the state for communities who are thinking of starting a school-based health center.
3. Enhanced working relationship with both the schools and the hospital as a result of this initiative.

Lessons Learned:
1. "Tell the story. Tell the right story. Tell the right story right."
2. Keep your eye on the prize and don't fret the little stuff.

Capacity-building for MCH-focused Community Health Workers

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Replicated: No
Evaluated: Don't Know

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Essential MCH Functions:	MCH Initiatives
none	*none*

Description

Community Health Workers (CHWs) are community members who participate in training so they can promote health in their own communities. The Multnomah County Health Department (MCHD) has employed CHWs for over 30 years. In 1998, MCHD initiated an effort to expand and enhance the role of CHWs in its Field Services Program. Field Teams composed of community health nurses and CHWs in its Field Services Program. Field Teams composed of community health nurses, CHWs, and mental health consultants provide health education and support to pregnant and parenting women, their partners and other family members.

Along with developing a nontraditional recruitment and hiring process and strengthening support for CHWs, leaders of the initiative sought to develop an effective initial and ongoing training program. They partnered with CHW Committee of the Oregon Public Health Association (OPHA), which had already begun development of a training center for CHWs. An additional partnership with the Portland Community College Institute for Health Professionals enables the program to confer academic credit.

This partnership is part of a national trend in the CHW field. To develop training centers where CHWs from a geographic area can participate in training, gain academic credit, and develop the networks of support that are crucial for all professionals.

The Capacitation Center partnership has benefited from the involvement of a number of community-based agencies, whose staff have helped to shape the curriculum and who have participated in several pilot programs. Additional input for the curriculum came from the core roles and competencies identified in the Final Report of the National Community Health Advisor Study, and from the Community Health Education Center (CHEC) in Boston and the Community Health Training and Development Center in San Diego.

To date the Capacitation Center has conducted two small-scale pilots and one full-length pilot. Our next step is to seek additional funding in order to take the program to scale.

Objectives

Barriers Encountered

Barriers to the implementation of this project have included:

1. Lack of staff time dedicated to developing and implementing the Capacitation Center. The Manager of the Capacitation Center is also responsible for program development activities such as: development of CHW charting forms, implementation of a mentor program, development and implementation of program evaluation, and training and leadership development with community groups. Similar training centers in Boston and San Francisco have at least five full-time dedicated staff.
2. Suspicion on the part of community-based organizations that MCHD seeks control of all public health activities and is not responsive to their input and needs.
3. Opposition from CHW employers to allowing staff time to participate in initial and ongoing capacitation.

Strategies to Overcome

Funding Source: Local Government
Description of other sources: Short-term contracts with agencies and health systems.
Budget: $0.00

Role of Health Department:
The MCHD is the lead agency in the effort to develop the Capacitation Center, contributing substantial staff time and support to the effort. However, the MCHD seeks to involve community partners at all stages of planning, implementation and evaluation. Our intent is that the collaborative effort grow to include an ever-increasing number of partners.

Accomplishments:
Developed 240-hour curriculum that confers 16 hours of academic credit;
Conducted seven session pilot for HIV Outreach Workers at MCHD;
Conducted six session pilot focusing on diabetes content and CHW skills for Providence Health System;
Conducted full-scale pilot for new MCH-focused CHWs;
Collected both individual and aggregate-level evaluation data on all activities conducted;
Organized first annual Community Health Worker Day to recognize CHWs for their work and expand CHWs' professional network.

Lessons Learned:
Community Health Workers need training that is empowering and confers academic credit. They also need opportunities for networking and professional development. Capacitation Centers like the one under development by the MCHD can meet these needs, thus ensuring that CHWs make optimal contributions to our communities and our health care system.

Primary Prevention of Childhood Lead Poisoning

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Replicated: Don't Know
Evaluated: No

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Essential MCH Functions:	**MCH Initiatives**
EPSDT/screening	Community perceptions of health problems/needs
Lead poisoning	Environmental assessments
Increasing social support	Public advocacy for legislation & resources
Environmental Health, Safe/Affordable Housing	Special studies
Building coalitions & partnerships	MCH legislative activity
Building MCH data capacity	Housing/Health

Description

The Primary Prevention of Childhood Lead Poisoning project was designed to inform local City Council members of the impact of childhood lead poisoning and strategies for lead prevention through the production and use of data and graphics to support advocate efforts.

Objectives

The project seeks to improve access to local, safe, affordable housing in neighborhoods with extremely high risk of lead exposure for new mothers leaving hospitals with newborns.

Barriers Encountered

A major barrier to the success of the program was the tension between the adversarial and litigious strategies of trial lawyers and the public health and collaborative strategies of the city child program.

Strategies to Overcome

The project used the continued sharing of data to show the limited impact of "strict legalistic enforcement" and that other strategies and aid for innovative efforts must be considered to protect unexposed infants.

Funding Source: Local Government, MCH block grant funds
Budget: $10,000.00

Role of Health Department:

The Rhode Island Department of Health provides local testing data and vital record data to be used in mapping by the Providence Plan.

Accomplishments:

A $50 million bond is now being considered by City Council which contains $5 million earmarked to implement lead prevention strategy in the community.

Lessons Learned:

Most people would rather "fix the blame" than "fix the problem."

Fixing a Hole, or, Finding Revenue Where It Ought To Be

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Replicated: Yes
Evaluated: Yes

Essential MCH Functions:	MCH Initiatives
Family planning Prenatal care EPSDT/screening Expanded child health services Increasing access to Medicaid Staff training	Staff training Monitor enrollment practices for ease of use Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services

Description

Wake County Human Services (WCHS) once again faced a budgetary reduction in 2000-01, totaling $6.5 million leaving a $153 million operating budget for all health, mental health, and social service programs, and responsibilities. Nearly half of this amount would be achieved by managing staff vacancies to average 93 percent through the year, the remaining half came from program reductions and RIFs (Reduction In Force). An opportunity presented itself in the form of an overhaul of medical billing, as the State and HCFA required movement to universal CPT and ICD9 coding - even though all payment rates were to be adjusted downward with the institution of these new codes (e.g. prenatal clinic visits, previously reimbursed at a flat rate of $101, would now be reimbursed at $17, $27, $45, $77).

Objectives

1. Compliance with State and HCFA billing changes.
2. Assessment of client family size and income to determine eligibility and sliding scale of adjustment to clinic fees (via placement of 'DSS' eligibility specialists in clinic administrative areas).
3. Maximization of revenue by applying appropriate billing coding and improving collections, both Medicaid and self pay (via redesigned encounter forms and aggressive staff training).
4. Relief from budgetary crisis, maintenance of staff without further RIFs (via improved collections and budgetary relief).

Barriers Encountered

1. The magnitude of billing changes and directions from the State which were often confusing, untimely, and poorly edited.
2. Concern that revenue was more important than service.
3. Concern that clients would bear the brunt of service reductions in inconvenience or in aggressive billing and collection practices.

Strategies to Overcome

1. Aggressive monitoring, consultation, and amendment of State directives.
2. Aggressive training of staff.
3. Assurances regarding intent to serve all clients regardless of ability to pay, but asserting that ability to pay even a reduced fee on sliding scale represents an ability and obligation to pay.

Funding Source: Local Government
Description of other sources: County government funds for operational support. Third party reimbursement-Medicaid, Other DSS matching funds for income eligibility specialists
Budget: $0.00

Role of Health Department:
Clearly, a response to a State and HCFA initiative, and a county budget crisis; except for State consultant work to review and affirm our new billing practices, all efforts were conducted within the agency.

Accomplishments:
1. 'DSS' Income eligibility specialists were placed in clinic registration areas (and clinic administrative staff given the opportunity to apply and train for these positions).
2. Accuracy of income eligibility (family size and income determination) process improved dramatically, as specialists accessed 'DSS' information (bank accounts, employment security commission, tax records, etc.).
3. Design and implementation of new encounter forms using CPT and ICD9 coding, with staff training and frequent reassessment follow-up, and feedback.
4. Enhanced self-pay collections and Medicaid collections.

Lessons Learned:
1. In adversity, there is opportunity.
2. What might be considered a disaster can be reversed.
3. You can "make a silk purse out of a sow's ear."

"Not Me, Not Now" Adolescent Pregnancy Prevention Communications Program

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Replicated: Yes
Evaluated: Yes

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Essential MCH Functions:	MCH Initiatives
Teen pregnancy Schools & health connections Building coalitions & partnerships	Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Prepare, publish & distribute reports Development of models

Description

"Not Me, Not Now" is Monroe County's abstinence-based adolescent pregnancy prevention communication program. The program targets youths ages nine to fourteen. This program first began in 1994 to reduce the teen pregnancy rate in Monroe County.
The program is-based on five goals:
1. Communicating the consequences of teenage pregnancy.
2. Helping teens deal with peer pressure.
3. Promoting parent-child communication about sexuality and relationships.
4. Promoting abstinence among young teens.
5. Raising awareness of the problems of adolescent pregnancy.

Objectives

Through the use of this campaign, the Monroe County Department of Health plans to:
1. Reduce the rate of pregnancies of 15-19 year old girls in Monroe County.
2. Delay the initiation of sexual intercourse among adolescents in Monroe County.
3. Reduce the number of teens who think that they are able to cope with the responsibilities and consequences of a pregnancy during adolescence.

Barriers Encountered

1. How to get parents involved in talking to their kids about sex.
2. Lack of demonstrated efficacy for interventions that exclusively promote abstinence from sexual intercourse for young teens.
3. Engaging the nine to eleven age group.

Strategies to Overcome

1. Hired experts from Johns Hopkins University to assist in preparing and completing research prior to developing the "Not Me, Not Now" program.
2. Utilized Harris Interactive to measure progress.
3. Collaborative partnerships.

Funding Source: Local Government
Description of other sources: Revenue, NY State Abstinence Program
Budget: $900,000.00

Role of Health Department:

This program was developed as a partnership involving Monroe County Health Department, the county's Department of Communication and Special Events, Prevention Partner's Inc. (a community-based youth services organization) and the New York Agency (a Rochester, NY-based advertising agency).

Accomplishments:

1. Designed and conducted impact evaluation.
2. Developed a parents guide "Unlocking the Secret-A Parent's Guide to Communication With Your Kids." Over 50,000 copies of the parent packet were distributed to parents in Monroe County.
3. A video version of the Parent's Guide. Partnered with local grocery stores to get this to parents free of charge.
4. Conducted parent workshops.
5. Each year printed and distributed 5,000 posters in schools, community centers, pediatrician offices. A poster process guide was developed for each poster.
6. Sponsored a school-based educational series presented in elementary schools and middle schools in Monroe County - Postponing Sexual Involvement.
7. Interactive web site – in the first three months the web site received 13,000 contacts. Site is accessed by youth, parents, community educators, and youth program managers. The web site displayed the TV ads, radio spots, posters, and other campaign materials. To access: www.notmenotnow.org. The impact evaluation contained three components: impact on program awareness and beliefs among middle school age children, impact on self reported behavior among high school age student, and impact on adolescent pregnancy rates.

Lessons Learned:

Involve the kids. Young teens serve as the spokespeople.

Formed a Kids Advisory Board; they serve as program consultants.

Target kids ages nine to fourteen. Research confirms that these kids are still receptive to the message of delaying sex.

Multi-pronged communications model: TV, radio, billboards, in-theater advertising, web site and on educational components.

In Motion with Co-Location

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Replicated: Yes
Evaluated: Yes

Essential MCH Functions:

- Expanding maternity services
- Low birthweight/infant mortality
- Breastfeeding/nutrition/WIC
- Immunizations
- Teen pregnancy
- Teen parenting
- Reducing transportation barriers
- One-stop shopping locations
- Other outreach activities
- Case coordination
- Building coalitions & partnerships

MCH Initiatives

- Implement/support education services for special MCH problems
- Develop & promote MCH agenda and YR2010 National Objectives
- Promote compatible, integrated services system initiatives
- Provide outreach services
- Transportation & oter access-enabling services
- Referral systems, resource directories, advertising, enrollment assistance
- Identify high-risk/hard-to-reach populations & methods to serve them
- Provide, arrange, administer direct services
- Identify & report access barriers

Description

Over the last year, Winnebago County Health Department MCH services committed significant amounts of energy, staff time and resources towards co-location of MCH services at the local Department of Human Services. Beginning with the Teen Parent Service program enrollment offered at DHS, we expanded MCH services to include WIC and Family Case Management (FCM). We implemented creative programming such as budgeting classes, a Book Club, and a Baby Talk program that strengthens mother-child relationship. To increase compliance with FCM visits and to create interest in the FCM program, we have started up afternoon support and educational groups for clients, an alternative to one on one visits with a case manager. Immunization services will soon be available on site.

Services are targeted to provide support, education and assistance to at-risk populations, specifically teen mothers and mothers receiving Temporary Assistance To Needy Families (TANF). Services are extended to any woman in need of MCH services visiting the DHS office. To achieve a convenient one-stop shopping experience, services are provided on the same day that mothers are scheduled for an appointment with their DHS caseworker. Services are provided by one person. We strive to provide more intensive services to address the needs of clients experiencing multiple issues. Because mothers meet monthly with their DHS caseworkers, this allows us to provide more intensive monthly follow-up, potentially doubling our normal bimonthly visits with clients.

Objectives

1. The activity's objectives are the same as the objectives for program participants in the WIC, FCM and TPS programs. These include:
2. Increase the number of clients who receive adequate prenatal care from 72 percent to 75 percent.
3. Increase the number of clients enrolled in both WIC and FCM programs from 92 percent to 95 percent.
4. Reduce the rate of babies born at low birthweight, less than 2500 grams from 9.8 percent to 6 percent.
5. Reduce the rate of African American LBW deliveries from 17 percent to 13 percent.
6. Maintain the number of teen mothers who achieve a GED or graduate from high school at 26/year.
7. Increase the number of clients who receive prenatal education from 84 percent to 90 percent.
8. Increase the percentage of program participants who are up to date with immunizations by age 2 to 85 percent.

Barriers Encountered

There was significant staff resistance to being physically located at the DHS office due to the perceived negative, unfriendly environment at the DHS office. We also had difficulty creating a package of services that would best integrate the DHS service flow, client needs and programmatic requirements. Staffing the office was another challenge, given that staff were already working to full capacity on programs at the main health department sites.

Strategies to Overcome

The vision for how this new initiative could improve the health of mothers and babies was shared with staff repeatedly. An explanation of the advantages of co-location were used to persuade staff of the value of this project. Staff consistently mentioned the difficulty in finding hard-to-reach mothers due to a number of reasons, i.e., welfare to work, transient population. We recruited a core group of motivated, creative staff to spearhead a "co-location" committee. They worked together, providing the ideas, the initial energy and enthusiasm, and the commitment to begin their endeavor. Their intimate knowledge of the WIC and FCM programs also helped to overcome an additional obstacle that of recreating these services to be delivered in a different environment. Further, we packaged WIC and FCM services differently, sparking staff's interest in participating in something new that would hopefully motivate and encourage client participation, as well as meet the more unique needs of some of our clients.

Funding Source: MCH block grant, other federal funds
Budget: $47,750.00

Role of Health Department:

In partnership with DHS staff during all phases of planning and implementation, the health department has played a major role in all aspects of this program. The department initially presented the idea to DHS staff, coordinated meetings to further develop the idea, hosted an open house for DHS, health department, and administrative staff, and has funded improvements to the DHS site. The health department provides and trains a full complement of staffing for the three days that we are located at the office. Finally, the health department provides the momentum for continuing the initiative by holding ongoing meetings with DHS staff and administrators to refine programming through problem solving.

Accomplishments:

1. Expanding services from one program, offered on one day per week, to provision of multiple programs and services that are held three days a week.
2. Providing a seamless flow of services to clients, so that clients see their DHS worker, followed by a health department staff person.
3. Locating clients that we were unable to reach through traditional outreach efforts.
4. Using creativity to make ongoing, regimented programs more appealing to clients to meet their needs.
5. Increasing knowledge and awareness of health department services among DHS staff and clients.
6. Increasing referrals from DHS to health department for a variety of services, including environmental health services and family planning.

Lessons Learned:

Everyone deals with change differently. When starting something new and controversial, it may be more strategic to establish a core planning/implementation group. Once the idea has been implemented and the problems worked out, bring others along. Implementing an old program in a new way can breath new life into the program. Meet clients where they are, both physically and emotionally. Working across agencies and systems can accomplish more for mothers and children.

Prenatal Infant – Parent Attachment Project

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Replicated: Yes
Evaluated: Yes

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Essential MCH Functions:	**MCH Initiatives**
Prenatal care Expanding maternity services Home visiting Overcoming cultural barriers Increasing social support Case coordination Staff training Prenatal parent-child relationship Building coalitions & partnerships	Staff training Provide outreach services

Description

Our unique Prenatal Infant-Parent Attachment Project, provides prenatal support to families at high risk for unintended pregnancy, isolation, pregnancy after the loss of a previous baby, medically complicated pregnancy and insecure attachment between parent and child. New research in prenatal attachment and psychoneuroimmunology shows that prenatal and perinatal experiences have a profound influence on the physical, as well as mental and emotional health of children, and that consciousness and learning begin before birth and form the foundation of how humans relate. In promoting prenatal attachment, we provide a doula (birthing support professional) to each family, as well as other activities to enhance attachment, such as guided videotaping, massage, promotion of breast-feeding, nutrition consultation, relaxation through music and imagery, books and a daily pregnancy affirmation calendar. This year we began providing home-based services to high-risk families experiencing a medically complicated pregnancy or who have miscarried a previous pregnancy. We are contracting with a Parent-Infant Specialist who accompanies the Public Health Nurse or outreach worker on home visits, sees the family in the hospital or at home after the baby is born, provides staff with one-on-one and group training in assessment, intervention and referral, and offers ongoing consultation through monthly meetings with program staff.

Objectives

Improved birth outcomes: Shorter, more comfortable labors and birthings, with the parents reporting increased feelings of satisfaction (as measured by parent self-assessment and doula report).

Increased awareness of role of parents and their connectedness with the baby in utero and after birth, with enhanced knowledge of and relationship to the baby, consistency with clinic visits, and awareness of when to go to the hospital at the optimum time (as measured by parents' self-report and PHN/outreach worker, parent-infant specialist, doula and clinic records).

Establishment of volunteer network of doulas/labor companions to provide services to pregnant and parenting families through training of five to eight labor coaches.

Increased number of community members involved with Family Center leadership and resources, increasing by 20 percent the Center's volunteer participation.

Improved parent satisfaction with service availability and access, with 90 percent of families indicating increased satisfaction (as measured by client satisfaction survey).

Barriers Encountered

Coordination of the wide variety of services provided to families by a collaborative of professionals, agencies and community volunteers.

Systems issues such as transportation, language interpretation, access to supportive services, and childcare.

Availability of ongoing funding.

Strategies to Overcome
In the second year of the program, grant management was transferred from the Department of Public Health to a local Family Center. Improving coordination of services and streamlining the budgeting, record-keeping, and evaluation processes. Most importantly, it placed the program in the community, making it an organic part of the neighborhood and thus more inviting to families. Currently the Family Center is able to assist with transportation; public health provides language-interpreting services; local community clinics provide medical services. We are exploring continuation and expansion funding to replicate the program in other family centers in St. Paul next year.

Funding Source: Local Government
Description of other sources: Other Federal
Budget: $35,000.00

Role of Health Department:
With support and encouragement from management, nursing staff wrote a grant proposal for doula services which was funded by a community collaborative accessing federal medical assistance case management dollars. Public health staff initiated the partnerships, including public health, a Family Center, a community clinic, Early Head Start, and doula members of the Childbirth Collective. First-year implementation and evaluation was done by public health. Together public health and the family center director wrote the second-year proposal, which adds one innovation to previous services and activities: a Parent-Infant Specialist who provides home-based services to families with complicated pregnancies, and offers consultation and training to Public Health Nurses and outreach workers. Collaborative members meet monthly for assessment and planning. A master's-level student in the University of Minnesota School of Public Health Maternal-Child Health program is conducting the project evaluation.

Accomplishments:
Approximately 60 families have been served with doulas and/or Parent-Infant Specialist services and other program activities.
The Family Center recruited two board members from the community; in addition, four doulas have offered to volunteer their services for birthings.
Families are very receptive to services, especially since they are home-based, free, include incentives, and are culturally and linguistically appropriate. Program staff have enthusiastically embraced the program and incorporated new ideas and activities into their practice. Parents praise doulas, regarding the empowerment they experience in their birthings and their increased attachment to their babies, both before and after birth.
Twenty-five volunteers attended the labor companion trainings and are working with community families; with grant funding, two of these have gone on to complete formal DONA (Doulas of North America) training.
Early evaluation (primarily anecdotal) of the Parent-Infant Specialist services shows that parents report being more comfortable and emotionally involved with their babies both prenatally and postpartum, and express gratitude for the support they receive for their complicated issues of pregnancy involving loss (or possible loss).
Our collaborative partners are enthusiastic and supportive, allowing us to accomplish together what any one of us could not do alone.

Lessons Learned:
That there are huge benefits to placing the program in the community, among the people, rather than in a city-county agency.
That prenatal services by Public Health Nurses, outreach workers, doulas and the Parent-Infant Specialist make a difference in a family's attachment to a baby, both before and after birth.
That trying to accomplish too many goals in a limited amount of time and with a limited amount of staff/funding can make a program too complicated and difficult to evaluate and replicate.
That buy-in and cooperation by collaborative partners and active support by each partner's administration is critical.

WIC Check Express

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Replicated: Don't Know
Evaluated: No

Essential MCH Functions:	**MCH Initiatives**
none	Provide, arrange, administer direct services

Description

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) is a federally funded program that has proven benefits in maternal and child health. The program provides supplemental nutritious food, nutrition education and breast-feeding support to categorically and income eligible women, infants, and children. Clients are determined eligible for the program at the initial certification or recertification visit and receive food instruments (checks) to redeem at participating grocery stores for the nutritious foods. At the certification appointment a nutritional assessment is performed and the client or authorized representative receive nutrition education and counseling. The client returns to the office during the certification period to pick up the food instruments at regular intervals.

The Pinellas County WIC Program in August of 1999 issued food instruments to 13297 clients. In September of 1999 federally mandated eligibility requirements were implemented that required the client to bring in proof of income, address, and identity. After the stricter eligibility requirements were implemented the Pinellas County WIC Program experienced a 15 percent drop in participation in three months time. The administrative staff of the WIC Program reviewed ways to break down barriers to service and increase participation. The Healthy Start Consumer group had identified the wait and the space available for clients in the WIC office in St. Petersburg as a barrier to service.

The staff in the St. Petersburg WIC office recognized the need to separate out the two basic types of appointments in the WIC Program so the certification process would not interfere with the check pick up appointment. The separation of the appointments was attempted on the third floor WIC clinic; this was never achieved successfully. It had been suggested by the state WIC office that the health department may want to consider moving WIC services to the first floor for better access to services.

The concept of a check out express lane used in retail department stores was transformed into a WIC check express workstation on the first floor of the St. Petersburg Clinic Center. The WIC check express "lane" would be for clients who are receiving "WIC checks only." The need for space on the first floor and the support of the Management Information Systems Division was determined necessary in getting the workstation set up to issue checks. Prompt support brought about the timely establishment of WIC Check Express, with a workstation located right inside the front door of the clinic center on the first floor.

Objectives

The objective was to decrease barriers to client participation in the WIC Program for the purpose of increasing the numbers of clients participating in the program. The barriers were identified as waiting time and space. The St. Petersburg third floor clinic area was rearranged to allow more space for client seating. The first floor check express lane kept the clients who were only picking up checks out of the clinic area, to even further reduce crowding. In addition, the clients who picked up checks where able to get checks faster in check express. As noted above the client participation in December 1999 was 11,322 countywide. By June of 2000 participation had increased to 12,323. In the St. Petersburg Clinic, participation in December 1999 was 3,328, which had increased to 3,568 by June 2000 and to 3,753 by December 2000 for an overall increase of 12 percent in one year.

It was also reported back to the Pinellas County WIC Program by the Healthy Start Consumer Group that the changes in the St. Petersburg clinic were effective in reducing the waiting time and reducing crowding.

Barriers Encountered

The obvious barriers that one would imagine in this venture would be space and equipment. However, these barriers were quickly overcome with the help of the administrative staff of the Pinellas County Health

Department. The greatest barrier was the resistance from the WIC staff. They wanted to stay on the third floor where the WIC records and workstations were located, and where they were in familiar surroundings.
Initially there was also resistance from the clients. Since they were able to receive checks on the first floor, they also wanted to conduct all their business at check express, including seeing the nutritionist for counseling and education.

Strategies to Overcome
The change in the way the St. Petersburg Clinic delivered services was discussed with staff and they were allowed to express their misgivings. Staff were asked to give WIC check express a try. After the initial implementation and working out confusion over which client needed to receive services on the first floor, the staff agreed that WIC Check Express was working.
Clients needed to be oriented to what services were available on the first floor.

Funding Source: Other Federal
Description of other sources: WIC
Budget: $21,800.00

Role of Health Department:
The Pinellas County Health Department provides all WIC services in Pinellas County, including planning, implementing and evaluation of all activities with funding provided through the Bureau of WIC and Nutrition Services in the Department of Health.

Accomplishments:
The major accomplishments are a reduction in the waiting time for check pick up appointments and a reduction in the crowding of the third floor WIC clinic as reported by the Healthy Start Consumer Group. The decrease in waiting time for checks was helpful to clients who work since it decreased the amount of time taken off of their job. Check express also helped participants become more responsible in bringing the required information for certification. If all the information was brought in at certification they could then pick up checks on the first floor at the next appointment instead of going to the third floor. And also a portion of the increase in participation can be attributed to the use of WIC check express.

Lessons Learned:
It is important to listen to consumers and act on the information they provide about service delivery. The Pinellas County Health Department and the consumers worked together to identify and solve a problem and improve services. Concepts used in retail establishments can be used in a public health setting to make services more convenient for the clients.

Reduce Teen Pregnancy for Marion County

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Replicated: Don't Know
Evaluated: No

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Essential MCH Functions:	MCH Initiatives
Family planning Teen pregnancy	Community perceptions of health problems/needs Population surveys (BRFS. PRAMS, PedNSS, YRBS) Hotlines, print materials, media campaigns Implement/support education services for special MCH problems Detention settings, foster care, mental health facilities

Description

Reducing teem pregnancy became the major focus for the management team of the Marion County Health Department in 1997. The teen pregnancy rate was at an all time high of 26.6 per thousand (ages 10-17). A multifaceted workgroup consisting of nurses teaching STARS (Students Today Aren't Ready for Sex); health department managers from family planning, adolescent health, and community contracts met twice monthly to review local data and develop a plan to involve the community.

Local data sorted by ZIP codes helped the team focus on higher risk areas. State data from birth reports provided more information about the socioeconomic conditions and ethnicity for the specific ZIP codes. The STARS team focused their attention on reaching adolescents in the high pregnancy rate ZIP code areas first.

The workgroup developed and wrote a teen pregnancy profile booklet to be utilized by the Marion County Health Advisory Board and other community leaders. The booklet included county pregnancy data, and profiled the higher ZIP code areas. It included a variety of resources to help with teen pregnancy issues.

Objectives

Obtaining community awareness of the teen pregnancy issue was the main objective of this workgroup. Best practices in teen pregnancy prevention have demonstrated a need for a variety of approaches in order to reduce rates. The goal was to reduce the Marion County teen pregnancy rate to be equal with the state rate of 18 percent.

Barriers Encountered

The health department workgroup favored a multi-choice system of education and services to involve all of the community. The county school system focused only on abstinence programs. School-based health centers were not welcomed because of the controversy regarding contraception in schools. One county official was not favorable of providing teens contraception without parental approval.

Strategies to Overcome

1. The action plan for the 1998-2000 agenda for the Health Advisory Board was teen pregnancy prevention.
2. The "old" Teen Parent Consortium changed their focus from support for teen parents to pregnancy prevention.
3. The Teen Parent Consortium combined forces with RAPP (Reduce Adolescent Pregnancy Program) to write and obtain a grant for "Parent-Child Talks."
4. ZIP code data demonstrating the higher rates in some areas of the county became the format for the STARS programs and outreach for teen pregnancy prevention. Over 18 middle schools with 2,261 sixth graders and 619 seventh grade children participated in STARS.
5. The teen pregnancy booklet was presented to the Children and Families Commission, Adult and Families Services, Services to Children and Families, county commissioners, church groups, school boards, and other community groups.
6. The Family Planning Advisory Board consisting of community members, also dedicated their time to reducing teen pregnancy.
7. A special Medicaid waiver for family planning in Oregon began in 1999. This waiver provides free contraceptive services to all US citizens under 185 percent poverty.

8. Marion County family planning clinics were expanded to include teen clinics, later hours, and rural areas.
9. A special grant was obtained to provide family planning to adolescent girls in juvenile detention.
10. A county commissioner became involved in teen pregnancy prevention. Three community forums were held in various geographic areas of the county. Different views on sexuality and education were presented resulting in provoking discussions from the audience.
11. Emergency contraception became readily available for all requesting it at the health department.
12. Male involvement began in earnest with the first "Boys Summit." The Department of Justice sponsored this event, with only boys or men invited. Over 400 men and boys attended the first event.
13. RAPP obtained a grant for the Americorp volunteer to work with teen mothers to prevent second births.
14. The 26th Annual Sexuality Conference (sponsored by Marion County Family Planning) had the largest attendance to date (550 attendees).
15. RAPP and the local county family planning clinic partnered on ads for abstinence with four billboards placed at various points in the city.
16. Bus ads were placed as the result of a collaboration between Planned Parenthood and the health department.

Funding Source: Various
Budget: $5,000.00

Role of Health Department:
1. Continuous monitoring of pregnancy rates.
2. Facilitating collaborations.
3. STARS.
4. Parent-Child Talks.

Accomplishments:
1. Reduction of the teen pregnancy rate to 16.5 percent from 26.6 percent. This is the first time in over a decade that Marion County has not been in the top three for highest teen pregnancy rates in the state.
2. Education to over 2,880 children about STARS.
3. Community awareness of the teen pregnancy issues.
4. Partnerships between agencies such as the Department of Justice, AFS, health department, schools, churches, and community progress teams.
5. Resource lists have been gathered and distributed as references for services available for teen pregnancy prevention efforts.

Lessons Learned:
1. Continuous monitoring of community health related data and bringing that information forward to policy makers, commissioners, schools, churches and public agencies, etc. can help unify a community to work toward the end objective.
2. Data is crucial to proving the significance of a health issue with long ranging effects. Data helped direct teen pregnancy prevention efforts towards ZIP codes with higher rates. Data demonstrated specific demographics in the ZIP codes referring to poverty, drop-out rates, single versus married teen mothers, risk factors of alcohol or other drugs, abuse, and juvenile crime.
3. Support from health department administration and management team makes the whole process easier.

Education, Career, Health, Opportunity (ECHO)

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Replicated: Don't Know
Evaluated: No

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Essential MCH Functions:	MCH Initiatives
Teen pregnancy Expanding private sector links Schools & health connections	Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them

Description

The Education, Career, Health Opportunity (ECHO) program began in 1999 with four county professionals with encouragement from the California Women's Leadership Institute. The Alisal High School with the highest rate of teen pregnancy was chosen for the first year. Fifteen girls were taken into the program which consisted of a discussion every other Wednesday night with a different woman professional. The girls were shown the options they had. They were given day-planners, journals, day-packs and T-shirts to remind them to plan their life and prepare for the future. There were opportunities for new experiences as the girls went as a group to Sacramento, the State Capitol, Stanford University, and University of California, Davis. The second year 16 girls were enrolled and 15 of them graduated from high school. None of the girls became pregnant. One of the Wednesday activities was learning how to study for the SAT, and applying to college and financial aid. Several of the girls said they would have never thought of doing this had they not been mentored.

Objectives

The objective is to increase the self-esteem of young women. This would allow them to postpone pregnancy and give them hope for the future. Having options for the future, these young women can develop to their full potential, and avoid the cycle of poverty.

Barriers Encountered

Lack of a coordinator and not having enough time for recruitment, and planning. Lack of funding to expand the program, both in the number of girls in the program and the types of adventures and activities they are able to participate in.

Strategies to Overcome

Group mentoring allows the mentors to be more flexible and have more security.
Working with the Charitable Council to apply to the Packard Foundation for a $400,000/3-year grant in order to hire a full-time coordinator and expand to offer the program to girls 9 to 19 years in two other high schools.

Funding Source: Private Source
Description of other sources: Women's Foundation of San Francisco
Budget: $15,000.00

Role of Health Department:

The health department encouraged and permitted the staff to use their talents on County time to initiate the program. One of the original founders and currently three of the mentors are from the health department.

Accomplishments:

None of the women have become pregnant. In the first year 12 of the 15 girls graduated from high school. In the second year all 17 girls graduated from high school. Several girls have applied to four-year colleges.

Lessons Learned:

It was surprising to the staff how narrow the world is for these girls and young women. There were surprises as the girls were taken to the State Capitol, Stanford University, and University of California, Davis. This was a new world for them and the mentors saw a new world from their eyes.

Analysis of Perinatal Outcome

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Replicated: No
Evaluated: No

Essential MCH Functions:	MCH Initiatives
	Community perceptions of health problems/needs Population surveys (BRFS. PRAMS, PedNSS, YRBS) Maternal, fetal/infant, child death reviews Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Assessment of provider reports regarding process and outcomes Prepare, publish & distribute reports Special studies Develop & promote MCH agenda and YR2010 National Objectives Consistent, coordinated policies across programs Staff training Support of health plans/provider networks Referral systems, resource directories, advertising, enrollment assistance Monitor enrollment practices for ease of use Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Identify & report access barriers

Description

Provide insight into factors affecting LBW (low birthweight babies) that may or may not be the same in SLC as throughout the rest of the nation. Use information to better identify women in our community at risk for LBW infants.

Objectives

1. A comprehensive survey will be done on mothers who delivered a LBW infant during the year of 1999.
2. Information from surveys will be analyzed for trends.
3. Interventions will be targeted at identified risk factors.

Barriers Encountered

1. Staffing.
2. Access to specific birth information and the ability to identify and interview women that had LBW infants in geographic area of interest.
3. Budget for participating staff (staff involved in survey or data analysis).

Strategies to Overcome

1. Flexible scheduling.
2. Utilize data available for other reporting purposes.
3. Involvement of community partners to assist in both the data gathering and in recommendation of improvements.

Funding Source: Local Government, MCH Block Grant
Description of other sources: Local funding
Budget: $0.00

Role of Health Department:
Outcomes of survey will be shared with community partners and strategies will be developed in an effort to reduce the incidence of LBW infants in the West Valley region of Salt Lake County.

Accomplishments:
We have partnered with Health Communities and other community partners to address this public health concern. The result is a hoped for decrease in the incidence of LBW infants in the West Valley Community.

Lessons Learned:
The need for utilizing community partners to impact a community health problem. Access to vital records to investigate the cohort in question has been difficult. We have not completed our project. We anticipate that we will learn many more lessons in the upcoming months.

Dysplasia Clinic

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Replicated: Don't Know
Evaluated: Yes

Essential MCH Functions:	MCH Initiatives
Breast/cervical cancer	Promote compatible, integrated services system initiatives
Building coalitions & partnerships	Provide, arrange, administer direct services

Description

In the early 1990's the health department established a Dysplasia Clinic through grant funding from the Texas Department of Health. The clinic was successful through the mid 1990's. In 1995, Managed Medicaid and changes in TDH funding changed the census and operations of the clinic. Additionally, the continued need to provide additional family planning services caused the department to evaluate the allocation of resources. San Antonio Metropolitan Health District (SAMHD) began to investigate other means to assure dysplasia services within the community. The hospital district, officiated with the medical school, offered a dysplasia clinic, but it was difficult to access and request.

Objectives

1. Establish a partnership between the local health department at a federal quality health center for dysplasia services.
2. Secure a seamless system of care for the women who need dysplasia services.

Barriers Encountered

1. The federally qualified health center had never offered dysplasia services, so staff training and development of policy and procedure was necessary.
2. Equipment needed- SAMHD assisted by leasing equipment for very nominal fee.
3. Patient medical records- past recommendations finding and retrieving; referrals not documenting good medical history.

Strategies to Overcome

1. Meetings were held on regular basis.
2. Staff for SAMHD loaned to the FQHC to assist with upstart.
3. Continue to educate staff about new partnership.

Funding Source: Local Government,State, Third party reimbursment
Description of other sources: Local Foundation
Budget:

Role of Health Department:

1. Through quality assurance process, assure referred and exchanges are maintained.
2. Lease agreement with equipment.

Accomplishments:

Patients are being referred and reports sent back and forth between the agencies.

Lessons Learned:

Planning cannot be over stated.
More difficult finding and referring past patients' recommendations.

San Diego Kids Health Assurance Network

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Replicated: Don't Know
Evaluated: Yes

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Essential MCH Functions:

- Overcoming cultural barriers
- Expanding private sector links
- One-stop shopping locations
- Other outreach activities

MCH Initiatives

- Tracking systems
- Prepare, publish & distribute reports
- Development of models
- Develop & promote MCH agenda and YR2010 National Objectives
- Promote compatible, integrated services system initiatives
- Provide outreach services
- Referral systems, resource directories, advertising, enrollment assistance
- Monitor enrollment practices for ease of use
- Identify high-risk/hard-to-reach populations & methods to serve them

Description

San Diego Kids Health Assurance Network (SD-KHAN) is a community collaborative of hospitals, health plans, medical and childcare providers, schools, community-based organizations, faith entities and businesses that are coordinated by the Children, Youth and Families Division of the County of San Diego Health and Human Services Agency. The goal of SD-KHAN is to assure 100 percent of children in San Diego have health coverage and zero percent disparity through sustainable systems approaches that assess, refer, follow-up, and educate regarding health insurance coverage, and promote appropriate utilization and retention.

Objectives

By January 2001, 50,000 uninsured children would have health coverage.

Barriers Encountered

Overcoming community perceptions of Medi-Cal (Medicaid), the welfare system, and the fear of the Immigrations and Naturalization System.
Coordination of the myriad of agency and community activities relating to outreach.
Retention of coverage emerged as an issue.

Strategies to Overcome

Special education campaigns promoted Medi-Cal (Medicaid) as a health program, thus de-linking it from welfare. A media awareness campaign was conducted that generated over 1000 uninsured families seeking health insurance within ten weeks. Social services staff were given special sensitivity training. Information was developed in several languages clarifying health benefits available for immigrants and their children. Other systems changes were implemented.
Monthly communication and coordination meetings were set up with Health and Human Services Agency staff including: CYF/MCH, Medi-Cal, Managed Care, Contract Operations, Regional Operation.
Bimonthly meetings were facilitated for community partners to share information, get updates, coordinate activities.
A retention workgroup was convened to address specific strategies.
Enrollment does not mean utilization nor continued retention, therefore prevention and utilization messages were formulated.

Funding Source: Local Government, State, Other Federal
Budget: $700,000.00

Role of Health Department:
Provide the leadership to develop, plan, implement and evaluate, and most importantly, provide feedback, as well as coordinate efforts.

Accomplishments:
From July 1998 - December 2000, more than 51,000 uninsured children in San Diego County have enrolled in health insurance programs. Many new community partners have joined the outreach and enrollment efforts.

Lessons Learned:
Takes multi-pronged approach - media, outreach, policy changes, etc.
Takes involvement of many partners such as employers, businesses, schools, faith community.

Perinatal Liaison

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Replicated: Yes
Evaluated: No

Essential MCH Functions:	**MCH Initiatives**
Other outreach activities Ref. Of pregnant women for home visiting	

Description

A Public Health Nurse (PHN) housed at the Department of Social Services interviews all pregnant women who come in to apply for Medicaid or TANF assistance. She refers the women for prenatal care and to other services for case management, such as PHNs in the community or community-based programs which provide home visiting services to immigrant and/or homeless women. She also consults with parents who may come in with children and need referral for health care and provides health care and referral information for the social work staff.

Objectives

1. Increase access to health care for pregnant women.
2. Increase the number of pregnant women receiving prenatal care in the first trimester.

Barriers Encountered

Ensuring that funding is available, and the Social Service Agency has office space for the nurse.

Strategies to Overcome

Data shows the cost effectiveness of having a staff available for early care, and the support provided to the social service staff, but making the health care referrals. This team approach improves the total service to the client.

Funding Source: Local Government
Description of other sources: Matched by Federal Medicaid FFP dollars
Budget: $100,000.00

Role of Health Department:

This is a program of the health department which planned, implemented, and is regularly evaluating the program.

Accomplishments:

Approximately 500 women have been interviewed and referred for care in a year.

Lessons Learned:

Social services and the health department can work effectively together to improve the health and social environment for clients who qualify for the services. We have developed other partnerships in child care, foster care, and mental health.

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Companeras: Systematic Data Collection to Determine Program Effectiveness

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Replicated: No
Evaluated: No

Essential MCH Functions:	MCH Initiatives
Family planning Prenatal care Expanding maternity services Home visiting Low birthweight/infant mortality Breastfeeding/nutrition/WIC Overcoming cultural barriers Reducing transportation barriers Clergy & health connections Other outreach activities Increasing social support Case coordination Increasing access to Medicaid Securing MCH assistance	Provide infrastructure/capacity for MCH functions Provide outreach services Transportation & oter access-enabling services Monitor enrollment practices for ease of use Identify high-risk/hard-to-reach populations & methods to serve them

Description

The Sisters/Companeras was founded in 1991 as a program to provide paraprofessional assistance to pregnant women. The program was originally designed to empower women to gain more control over their pregnancies, birth outcomes, life issues. In 1995, the Sisters/Companeras program became a part of the Farm Workers Association of Florida.

Objectives

Provide liaison support between women and medical services.
Provide home visits, referrals and counseling, support groups, and pregnancy education.

Barriers Encountered

The greatest barrier faced by the Sisters/Companeras paraprofessional liaisons is the lack of resources and support staff. The original program sought funding for at least four paraprofessionals, whereas there are two.

Strategies to Overcome

Data indicates that the program is very successful. The CityMatCH DUI team has designed an evaluation component to systematically document the success of the program to ensure future funding.

Funding Source: Local Government
Budget: $60,000.00

Role of Health Department:

The health department has been taking a leadership role in partnering with March of Dimes and Healthy Start to develop an evaluation plan for the Sisters/Companeras program.

Accomplishments:

The project has had many accomplishments with regard to the goals set. The way in which the evaluation plan was designed, we hoped would lead to the development of an empowerment model. This empowerment model sought to actively engage project staff in the design and implementation of evaluation tools. While staff provided considerable amounts of feedback on format and content of the evaluation forms, we feel that they failed to take ownership of the project which we feel was more a result of the process.
Among the lessons we learned from the project:

1. Need for consistent communication and consensus with partner organizations.
2. Attentiveness to cultural barriers.
3. Need for cultural sensitivity and connectedness in group dynamics.
4. Awareness of historical relationships in targeted areas.
5. Awareness of the socio-historical elements that give the targeted area the unique characteristics that have been conducive to the success of the various social programs/movements attempted in the target area.

Lessons Learned:
One of the most important lessons learned from the evaluation process has been the recognition that for a project like this to be replicated in another location successfully there are characteristics within the community that need to be met. Historically, the Sisters/Companeras program has been fueled by an active community residence.

Adolescent Health Report

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Replicated: No
Evaluated: No

Essential MCH Functions:	**MCH Initiatives**
Increasing access to adolescent health care	Community perceptions of health problems/needs Prepare, publish & distribute reports Improving quality of adolescent health services

Description

Publication of a comprehensive data resource on adolescent health--"Sonoma County Adolescent Health Perspective: Data Profile and Recommendations for Action." Activities accomplished to publish the report included:

1. Organizing a planning committee.
2. Defining a target audience for the report and purpose of the publication.
3. Deciding content or subject areas to be included in the report.
4. Identifying and collecting data.
5. Researching literature.
6. Analyzing data.
7. Writing interpretation of data and qualitative information for each subject area.
8. Deciding the process to obtain youth perceptions of health issues.
9. Obtaining photos of local teens involved in typical activities.
10. Developing and administering teen survey, organizing teen focus groups and interviews.
11. Integrating teen input into the document.
12. Coordinating review of document by subject experts.
13. Coordination of graphic design and printing of document.

The report will be presented to the County Board of Supervisors and released to the public through a press conference. The document will be on the internet and copies will be mailed to all adolescent service agencies and policy makers.

Objectives

1. To increase community awareness of the health status of youth in Sonoma County.
2. To identify health care service needs for adolescents.
3. To increase the quality of health care and access to health services for youth.

Barriers Encountered

The most difficult task in publishing the adolescent health data resource was getting consensus of the planning committee, Maternal Child Adolescent Health Advisory Board and Department of Health Services on whether the report would contain data and analysis of data and/or recommendations for community action. Since the data report was written by different professionals, it was difficult to integrate sections so the document was written in the same style with and active voice. Information flowed from one section to another.

Strategies to Overcome

Reaching agreement on the purpose and content of the data report was accomplished by getting most of the individuals in the three groups together at one time to discuss the approaches. Ultimately a decision had to be made and communicated by the project coordinator so the project could move forward. The writing style and the sections were integrated by contracting with an editor.

Funding Source: MCH block grant
Description of other sources: Local Govt, Private Foundations, Hospital Community Benefit Funds
Budget: $8,320.00

Role of Health Department:
The MCH program provided staff support for setting meeting times, forming agendas, recording minutes, distributing minutes, and facilitating the meetings for the planning committee that decided the process for developing the report, as well as the content of the report. MCH coordinated all aspects of the project such as: obtaining photos of teens through a photography class at the local junior college, developing a survey and soliciting college students or interns to administer the survey questions, coordinating focus groups of teens, providing incentives for teens for participating in the survey interview, identifying and contracting with a graphic artist and editor and arranging for printing of the document. The Health Services epidemiologist coordinated all data collection by various members of the committee and community, analyzed data, wrote data interpretations and arranged for various experts to review subject areas of the report.

Accomplishments:
1. Identification of available data sources on adolescent health indicators and gaps in data that need to be developed.
2. Publication of a source data document on adolescent health for policy makers and program planners.
3. The project brought a diverse group of community adolescent health professionals together to accomplish the data report.
4. The publication represented teens and their diversity with pictures of local teens and quotes from teen interviews infused throughout the document.

Lessons Learned:
1. It is important to have an epidemiologist on the team so that the data and the interpretation of the data is accurate.
2. It is helpful to review existing adolescent data reports to determine the format of the report, to identify data sources, and determine adolescent issue areas for the report.
3. It was extremely helpful that we were given permission to use data templates developed by the National Adolescent Health Information Center, University of California, San Francisco.
4. It is also important to get consultation from an expert in the subject area such as the National Adolescent Health Information Center to determine the purpose and messages to impart in the publication and hear about the lessons they learned.
5. Having experts from several disciplines review sections of the report relevant to their experiences and specialties assures accuracy and quality of the data and information.
6. Obtaining the input of teens through surveys, interviews, or focus groups is critical, so that the data truly reflects teens in our community and their concerns.
7. The cost is higher than planned to produce a quality document.

A Community Response to Infant Mortality

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Replicated: No
Evaluated: No

Essential MCH Functions:	MCH Initiatives
Prenatal care Low birthweight/infant mortality Overcoming cultural barriers Other outreach activities Increasing social support Building coalitions & partnerships	Community perceptions of health problems/needs Development of models Newsletters, convening focus groups, advisory committees, networks Identify high-risk/hard-to-reach populations & methods to serve them Identify & report access barriers

Description

In response to disparities in infant mortality rates between African Americans, Native Americans and Whites in Seattle and King County, the health department has embarked on development and implementation of a community organizing strategy to mobilize individuals, groups and organizations to identify and develop community buffers to address these disparities.

Objectives

1. Develop a model that describes the connection between racism, stress and poor pregnancy outcome, and the potential influence of social support (community buffers).
2. Convene community groups in African American and Native American communities to begin development of community organizing strategies.
3. Work with community groups to identify and develop social interventions to address institutional racism and its effect on pregnancy outcomes.
4. Work with local institutions such as hospitals to participate with community groups to begin internal processes necessary to address root causes of health disparities, including institutional racism.

Barriers Encountered

1. Institutionalized racism in local institutions, which hampers efforts to encourage real community input.
2. A traditional "top-down" approach to obtaining and using community input.
3. Lack of funding for community development.
4. Lack of information and lack of a coordinated effort at the community level.

Strategies to Overcome

We have worked with IntraAfrikan Konnections, a community consultant group, to develop a community development model for addressing racial disparities in pregnancy outcome, and to convene preliminary community groups in preparation for development of communities organizing on this issue.
We have sought grant funding for community organizers in the African American and Native American communities to begin the community organizing necessary for development of social interventions. We obtained commitment from the Director of Public Health, Seattle and King County, to fund the Native American community organizer for one year.
We have also sought grant funding for an effort to work with a local major teaching hospital to begin an internal process for addressing institutionalized racism, as it affects its own hospital's racial disparities in infant mortality. Public health staff and staff of the agency members of the Infant Mortality Prevention Outreach Network attended "Undoing Institutionalized Racism" training, to prepare for work at the institutional level.

Funding Source: Local Government, Other Federal
Budget: $48,175.00

Role of Health Department:

1. Provide city funding through a contract with IntraAfrikan Konnections, the community consultant group, to begin the community development process.
2. Provide city funding for attendance of 20 individuals in UIR training.
3. Provide logistics, supplies and refreshments for various community and grant-writing meetings.
4. Provide coordination of communication when necessary, keeping multiple community and constituent groups informed of the process.
5. Provide technical assistance with grant writing and grant preparation.

Accomplishments:

1. We have been able to continue to convene a small group of Native American women who are looking at racial disparities in infant mortality, and have found funding for a coordinator through public health, who will be housed at a local Native American community service agency.
2. We have been able to keep current organizations informed of the continuing processes, including the King County Infant Mortality Prevention Outreach Network.
3. We have written two grants seeking funding for the activities; one grant to the Office of Minority Health, and one to the Washington Health Foundation.

Lessons Learned:

Community organizing and community process are hard work. It is necessary and valuable to keep constituents informed and involved every step of the way, despite the fact that this communication appears to slow down the process. It is important to look at our own institution's role in continuing the institutionalized racism that affects our African American and Native American communities. With this in mind, it is particularly important to "get out of the way" of the community, and to provide support and technical assistance only when necessary, and not to direct the process. This requires practical self-reflection every step of the way. It is also important to encourage representatives of other institutions to examine their own institution's roles in continuing policies that perpetuate disparate treatment of African American and Native American communities.

ABCDE-Expanded

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Replicated: Yes
Evaluated: No

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Essential MCH Functions:

- Prenatal care
- Expanding maternity services
- Early intervention/zero to three
- EPSDT/screening
- Expanded child health services
- Children with special needs
- Dental programs
- Overcoming cultural barriers
- Reducing transportation barriers
- Expanding private sector links
- Increasing social support
- Case coordination
- Increasing access to Medicaid
- Staff training
- Strategic planning
- Securing MCH assistance
- Building coalitions & partnerships

MCH Initiatives

- Community perceptions of health problems/needs
- Tracking systems
- Population surveys (BRFS. PRAMS, PedNSS, YRBS)
- Hotlines, print materials, media campaigns
- Culturally appropriate health education materials/programs
- Implement/support education services for special MCH problems
- Assessment of provider reports regarding process and outcomes
- Prepare, publish & distribute reports
- Public advocacy for legislation & resources
- Special studies
- Development of models
- Develop & promote MCH agenda and YR2010 National Objectives
- Newsletters, convening focus groups, advisory committees, networks
- Promote compatible, integrated services system initiatives
- Consistent, coordinated policies across programs
- MCH input in legislative base for health plans & standards
- Staff training
- Support of continuing education
- Support of health plans/provider networks
- Provide outreach services
- Transportation & oter access-enabling services
- Referral systems, resource directories, advertising, enrollment assistance
- Pediatric risk adjustment methods & payment mechanisms
- Identify alternative resources to expand system capacity
- Comparative analysis of HC delivery systems
- Profiles of provider attitudes, knowledge & practices
- Identify & report access barriers

Description

ABCDE staff and key dental providers will train pediatricians to provide basic oral health care as a part of the child/youth medical examinations, provide up to three fluoride varnish treatments per year to children through age 19 years in concert with similar dentist provided treatments, and refer patients to dental service providers for follow-up care. To accomplish this we will:

1. Recruit 50 pediatricians, family practice physicians, and current dental service providers for project participation.
2. Utilizing participating dental providers and Spokane Regional Health District (SRHD) staff, provide training to physicians and other key staff.
3. Client outreach, education and enrollment will be accomplished by SRHD.
4. Program evaluation activities will be conducted.

Objectives

1. Provide oral health assessment, care/education to underserved children/youth populations from zero to six years of age, achieving a 40 percent reduction in cavities among participating youth.
2. 50 pediatricians and family practice physicians will be recruited to participate in this program.
3. 50 pediatricians and family practice physicians will provide oral health screening and fluoride varnish application as a part of their child/youth care to at least 50 percent of children in their practice from zero to six years old for the first year.
4. The medical providers will provide referral for oral health care, such as routine or emergent, to participating dentists in the community.

Barriers Encountered

1. Sufficient start up and maintenance funding.
2. Overcome the perception that dentists take care of the mouth and physicians take care of the rest of the body.

Strategies to Overcome

Barriers will be addressed when the program is implemented and a steering committee is formed to review.

Funding Source: Third Party reimbursement, Private Sources

Description of other sources: Washington State Dental Association, Group Health Foundation

Budget: $340,530.00

Role of Health Department:

SRHD's role has been the catalyst, convener and facilitator in working with our community partners in dental and medical care.

Accomplishments:

Key child dental providers have endorsed the concept and are participating as a part of the presentation team to the medical providers.

The first meeting with the pediatricians was well attended and enthusiasm was expressed for the proposed program.

Grant Application process started with Group Health Foundation of Washington.

Approval has been received to match 50 percent of the program's costs through Medicaid.

Lessons Learned:

We anticipated some of the long time dentists would be threatened by including physicians as an active partner in children's preventative dental care. We have found some resistance.

Syracuse Healthy Start Registry

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Replicated: No
Evaluated: Yes

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Essential MCH Functions:

- Family planning
- Prenatal care
- Home visiting
- Low birthweight/infant mortality
- Substance abuse prevention
- Breastfeeding/nutrition/WIC
- Early intervention/zero to three
- Expanded child health services
- Lead poisoning
- Children with special needs
- Adolescent school-linked/based services
- Violence prevention/at risk
- Teen pregnancy
- Teen parenting
- Communicable diseases
- Family violence
- Overcoming cultural barriers
- Reducing transportation barriers
- Expanding private sector links
- Clergy & health connections
- Schools & health connections
- Other outreach activities
- Increasing social support
- Case coordination
- Increasing access to Medicaid
- Staff training
- Strategic planning
- Reshaping urban MCH
- Securing MCH assistance
- Managed care initiatives
- Building coalitions & partnerships
- Building MCH data capacity

MCH Initiatives

- Community perceptions of health problems/needs
- Tracking systems
- Maternal, fetal/infant, child death reviews
- Hotlines, print materials, media campaigns
- Culturally appropriate health education materials/programs
- Implement/support education services for special MCH problems
- Assessment of provider reports regarding process and outcomes
- Prepare, publish & distribute reports
- Public advocacy for legislation & resources
- Development of models
- Develop & promote MCH agenda and YR2010 National Objectives
- Newsletters, convening focus groups, advisory committees, networks
- Promote compatible, integrated services system initiatives
- Consistent, coordinated policies across programs
- MCH input in legislative base for health plans & standards
- MCH legislative activity
- Provide infrastructure/capacity for MCH functions
- Staff training
- Support of continuing education
- Support of health plans/provider networks
- Provide outreach services
- Transportation & oter access-enabling services
- Referral systems, resource directories, advertising, enrollment assistance
- Monitor enrollment practices for ease of use
- Identify high-risk/hard-to-reach populations & methods to serve them
- Provide, arrange, administer direct services
- Detention settings, foster care, mental health facilities
- Managed Care model contracts & access issues
- Identify & report access barriers

Description

Syracuse Healthy Start (SHS) is funded by a four-year Healthy Start II grant from the Health Resources and Services Administration (HRSA) awarded in September 1997. SHS promotes community-based, comprehensive prenatal care and other facilitating services to women, infants and their families, and integrates these services into existing systems for a community with a high rate of infant mortality. The goal is to improve health outcomes by reducing infant mortality and adolescent pregnancy. The comprehensive plan includes a computerized monitoring system with social risk screening, referral and follow-up for preventive services including home visitation, in-service education for health care providers, community health promotion, and outreach.

The Syracuse Healthy Start Registry (SHSR) is a population-based monitoring system that began in April 1998 and acts as a surveillance tool for pregnant and parenting women and their infants through their first year of life. The initial aim of SHSR was to enroll all pregnant women and their newborns living in the designated 30-census tract area to track, assess and monitor for social risk. In January 2000, the project expanded to include the entire city, and now links over 50 health care and human services providers and community-based agencies. SHSR promotes healthier pregnancies and positive birth outcomes through risk reduction, community education, health education and community linkages. The system is-based on self-referral and provider referral. All consenting women and their infants are enrolled to receive a home visit and social risk assessment. They receive referrals, support, and assistance for identified needs including: access to Medicaid or other insurance, entry into prenatal care, WIC, domestic violence, substance abuse, smoking, housing, translation, transportation, and/or a history of childhood lead. For postpartum women, family planning is another critical component. Continuous follow-up with receipt of prenatal care and WIC insures that clients actively attend visits for these two essential services.

Objectives

In the project area, reduce infant mortality rate by 30 percent, increase adequate prenatal care to 75 percent, reduce women who receive late or no prenatal care to three percent, enroll 90 percent of all pregnant women, decrease smoking below 25 percent, increase initiation of breast-feeding to 50 percent, and decrease unintended births to 55.8 percent within a four-year period, and reduce LBW by 20 percent during the calendar year.

Barriers Encountered

Creation of an information system responsive to the surveillance needs of the project.
Maintaining the integrity of the database. Integration/networking of existing databases within our own agency.
In-service training designed to equip public health team members in the accurate collection and entry of data.
Registry staff development related to quantitative data analysis and its value for public health on a daily basis.
Fragmented data hinders data management and quality assurance.
Inability to directly access State databases/information systems for population and cross-referencing purposes.

Strategies to Overcome

The Registry team consists of a creative interdisciplinary team, which relies on a shared maternal child health, public health, and information systems knowledge base. The system designer worked closely with the nurse coordinator of the Registry to plan and develop the tracking system. Ongoing database design enhancement continues as a result of quality assurance and local and federal evaluation objectives. Continuing education of Registry staff members has focused on using and interpreting data and computer training. Future education will focus on quantitative data analysis and interpretation. Issues related to confidentiality continue to be explored. Enhancing tracking capabilities and coordinating outreach services effectively remains a primary objective. Integrating existing information systems within our own department in a cost effective manner that also addresses the policy and procedural changes for the collection of incoming client data remains a challenging task.

Funding Source: Local Government
Description of other sources: Federal Healthy Start Grant funds
Budget: $20,000.00

Role of Health Department:

The role of the Onondaga County Health Department's MCH Public Health Team, Healthy Start staff, Registry staff, and the health department's administrative staff has been one of collaboration in all phases of strategic planning, active involvement in the empowerment of all Consortium and community members, and ongoing and comprehensive evaluation in relation to the effectiveness of evidence-based interventions offered.

Accomplishments:

Since the inception of Syracuse Healthy Start, the infant mortality rate in the project area and the disparity in infant death between African American and Caucasian babies have declined. Additionally, low birthweight and very low birthweight births, adolescent births and repeat births to teen mothers have decreased.
The creation and successful implementation of a social/public health screening tool and corresponding protocols, consisting of intervention strategies, were developed to identify psychosocial risk behaviors. This tool is also used for quality assurance and is instrumental in evaluating current services and the creation of future programming.

Lessons Learned:

The value of planning within the department and between the department and area providers and agencies.
The value of intra- and inter-agency resources to create and sustain partnerships and impact the behaviors and health of the community. Focus groups and surveying are very helpful in accomplishing this end.
The essential element of evaluation as an ongoing tool in quality improvement activities. This has resulted in new policies and procedures relevant to the practice of preventive MCH, increasing the frequency of home visitation, improving the documentation of interventions and getting women into care earlier. Evaluation has also encouraged the refinement of data collection and improved the tracking and monitoring of Registry participants.
Empowerment of providers, community-based agencies, and community members through personal involvement has been a direct result of this federal funding.

Newborn Referral Program

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Replicated: Don't Know
Evaluated: No

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Essential MCH Functions:	MCH Initiatives
Home visiting Substance abuse prevention Violence prevention/at risk Teen pregnancy Teen parenting Family violence Case coordination Increasing access to Medicaid	Provide outreach services Referral systems, resource directories, advertising, enrollment assistance Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Universal newborn screening programs

Description

In 1994, a group of concerned businessmen, educators and human service providers came together to address the growing problem of abuse and neglect of children in Pierce County. Out of this group a coalition formed and became known as the Prevention Partnership for Children (PPC). The Tacoma-Pierce County Health Department is one of more than 30 members of the PPC whose mission is to prevent abuse and neglect of children and promote health outcomes in families through the provision of family support services. The Newborn Referral Program (NRP) was developed in 1998 as a means of identifying high risk families early in a child's life and referring them into Family Support Services.

The primary elements of the NRP are-based on studies which demonstrated the effect of nonmedical interventions on pregnant women and infants who were at greater than average risk for low birthweight, infant death and developmental delay. These studies show a marked decrease in poor health and psychosocial outcomes in families who received intervention initiated at birth.

Objectives

1. To screen the hospital records of all women who deliver at the nonmilitary hospitals in Pierce County to determine those who are facing the greatest challenges.
2. To offer those families information, support and a referral to a Family Support Center Public Health Nurse.
3. To provide home visits to those who are determined to require intensive support and follow-up and consent to accept services.
4. To assist families to become healthy both physically and mentally through assessment, intervention and referral to community resources.
5. To teach and model positive parenting skills.

Barriers Encountered

1. There was considerable resistance by hospital staff about allowing a nonhospital employee access to confidential records.
2. The hospital staff was also concerned about how the data we were collecting from the patient records was going to be utilized.
3. The hospital-based perinatal social workers were very concerned that the Public Health Nurses conducting the record screenings would be duplicating the service that they already provide.
4. Establishing a mechanism that would allow nonhospital employees to be housed and work on a daily basis in the hospital environment.
5. Determining a way to access records of deliveries that occurred on weekends or holidays.
6. Developing successful engagement strategies with women who were not visited by the PHN during their hospitalization yet screened in as high risk.

Strategies to Overcome

1. A written agreement was developed with each hospital that defined the scope of practice of the PHN within their organization, and clarified that the data collected from the charts would be maintained in a confidential database that would be used for statistical purposes with no names released. Patients must sign a consent that denotes agreement to receive home visits from a PHN. Once a consent form is signed that patient's information is released to the appropriate PHN only. A report is sent to each hospital on a monthly basis informing them of the number of screens completed and the number of referrals made.
2. The PHNs met with hospital staff and established a plan for how they would come together to screen and work with patients. Once the work started, the social workers and floor nurses readily accepted the PHNs and valued their work.
3. An agreement was made with the medical records department managers to allow the PHNs access to records of deliveries that occurred on weekends and/or holidays so that they may be screened for need. Some of the hospitals have even developed a system from within to assure that the charts are screened if the PHN is gone on leave.

Funding Source: Local Government
Description of other sources: General State funds, Other Federal funds
Budget: $230,358.00

Role of Health Department:

There was a request from the Prevention Partnership for Children (PPC) to develop a system that would establish a continuous flow of referrals of high risk, young children, into the Family Support Centers. The TPCHD, as a member of the PPC, volunteered to develop such a system. From that point forward we developed a draft plan and started discussions with hospital administrators and the staff on the Women and Newborns Services wards. Evaluation includes monitoring the data that is entered daily on all records screened to assess the number of high risk families identified and the number of referrals made. Furthermore, hospital staff are surveyed regarding their perception of the value of this program and how it is working.

Accomplishments:

Since 1999, 13,668 records have been screened and 2,129 referrals were made. Since the start of the program the screening tool has been revised several times as we identify certain trends in our community to assist in gathering data about these trends that could lead to policy development. For example, the July 2000 HRSA Community Health Status report identified our county as having high numbers of pregnant women who have no prenatal care in the first trimester. The screening tool was revised to include the questions "when did you enter prenatal care," and if they entered after the first trimester, the patient is asked why they started care at that time; e.g., no insurance, unable to find a provider, new to area, did not want anyone to know about the pregnancy, etc. By collecting this data we hope to address these barriers and make prenatal care more readily accessible. In addition, a collaborative effort has been formed between local public health and the hospitals, and high risk families who were missed during the pregnancy are now being identified and linked to early intervention/prevention services.

Lessons Learned:

Collaborations between public and private agencies take a lot of education and trust building before they can be successfully implemented. Once established many doors have opened in the acute care setting, laying the ground work for more collaborative relationships between public health and the hospitals in other arenas such as communicable disease control and prevention efforts. Providing ongoing feedback to each hospital regarding the number of patients who were referred and engaged with PHN for services has been very helpful.

Pima County Juvenile Court System STD Clinic

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Replicated: No
Evaluated: No

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Essential MCH Functions:	MCH Initiatives
Other outreach activities Screening and treatment for incarcerated youth	Community perceptions of health problems/needs Culturally appropriate health education materials/programs Development of models Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Detention settings, foster care, mental health facilities Identify & report access barriers

Description
Each Monday, a disease investigator visits the detention center to offer HIV counseling and testing. This person also screens for the Wednesday STD Clinic. One clinician and two ancillary staff provide services for four hours each Wednesday. The team provides clinical services, education and counseling. Youth who attend the clinic are provided with incentives they can use for food or phone cards if they continue with health services at the county teen clinic after they are released.

Objectives
1. To provide STD screening and treatment for up to 500 incarcerated youth in Pima County by February 2002.
2. To incorporate STD screening and treatment for incarcerated youth into the regular Title X array of services.

Barriers Encountered
1. Juvenile Justice System concerns regarding providing clinical services to minors without specific parental permission (ex. while allowing STD screening, won't allow Pap smears).
2. Physical limitations of providing clinical services in detention setting.

Strategies to Overcome
Ongoing education of Juvenile Court Administrators.

Funding Source: Other Federal
Budget: $58,000.00

Role of Health Department:
Needs assessment showed increased rates of chlamydia and other STDs among at risk teens being served at a county teen clinic. Many were involved with theJuvenile Justice System. Health department negotiated with juvenile justice system to bring the clinicians and health educators one-half day a week to provide STD screening and treatment in the detention center, along with appropriate health education. The health department obtained extra Title X funds to initiate project.

Accomplishments:
Project began only 13 months ago. The major accomplishment is the weekly increase in the number of youth served in the juvenile detention center. The project provides services for seven to twelve teens each week.

Lessons Learned:
Incarcerated youth have multiple complex health needs. One screening program will not begin to meet the needs of "an intensely needy" group.

FIMR (Fetal/Infant Mortality Review)

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Replicated: Don't Know
Evaluated: No

Essential MCH Functions:	MCH Initiatives
	Community perceptions of health problems/needs Maternal, fetal/infant, child death reviews

Description

Mortality review team for fetal and infant prior to one year of age. Review all deaths except abuse/neglect for possible systems changes to improve infant mortality rates.

Objectives

1. Develop timely, reliable means of death information.
2. Secure medical record sharing agreements with all providers.
3. Establish two dynamic and productive teams to review data and propose and implement systems-based improvement strategies.

Barriers Encountered

1. Confidentiality and medical record access.
2. Patience, persistence, creativity of team members.

Strategies to Overcome

1. Patience, persistence, creativity of team members.
2. Ensure key players from each agency/entity invited.

Funding Source: Local Government
Budget: $46,000.00

Role of Health Department:

Lead agency and funding source.

Accomplishments:

Getting all entities to table (medical examiner, hospitals, clinics, etc.)

Lessons Learned:

Importance of "buy-in" from all levels of participation.

Power of Prevention

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Replicated: No
Evaluated: No

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Essential MCH Functions:	MCH Initiatives
Building coalitions & partnerships	Community perceptions of health problems/needs Hotlines, print materials, media campaigns Culturally appropriate health education materials/programs Implement/support education services for special MCH problems Staff training Support of continuing education Transportation & oter access-enabling services Identify high-risk/hard-to-reach populations & methods to serve them

Description

The Power of Prevention is a collaboration that has been established between the American Cancer Society, Brazos Area Health Education Center, Hillcrest Health Systems, Providence Health care Network, and the Waco-McLennan County Public Health District. Power of Prevention is a year-round series of programs that strives to establish and maintain trusting relationships between local populations and health care organizations by providing the medically under-served in McLennan County with information and support to motivate them to adopt positive lifestyle behaviors. Examples of such programs are worksite lunch and learns, Heart Disease Risk Assessment, diabetes cooking demonstrations, osteoporosis screenings, church walking trail development, and an annual Power of Prevention Conference. Programs take place a minimum of once a month throughout the year, and often there are several programs during the month.

Objectives

To provide information and support to assist people in overcoming fear and anxiety concerning health issues.
To provide education about the importance of prevention, early detection and regular check-ups.
To provide instruction on how to recognize changes and symptoms in the body, and when to seek health care for those changes.

Barriers Encountered

The greatest barrier faced by the collaboration was finding a point-of-contact within each community and/or population.
Without a point-of-contact, it is very difficult to get involved in a community and have good participation in your programs.
We also rely heavily on the point-of-contact to provide feedback and information about topics of interest.

Strategies to Overcome

Churches were identified as "safe places" in most communities. Collaboration members began meeting with pastors and priests in different areas of the community. These local leaders were able to work directly with us in some cases and in others establish a contact person for that community. These contact people have proven invaluable in helping to find facilities, recruiting participants, providing childcare, and in program topic suggestions.

Funding Source: Private Source, Other
Description of other sources: American Cancer Society Unit Initiative, Waco Foundation Grant. Other: In-Kind contributions from each organization
Budget: $5,000.00

Role of Health Department:
The Waco-McLennan County Public Health District develops marketing and evaluation tools, recruits speakers, arranges for speakers' needs, coordinates event catering, uses existing networks for promotion, chairs and coordinates the Collaboration.

Accomplishments:
The Collaboration has provided presentations within the community at local churches, recreation centers, schools, and businesses. As the Collaboration works with these defined populations, relationships are cultivated to help facilitate and motivate change. This change is accomplished through raised awareness and preventative skills such as breast self-exams. Through the participation of major health care providers, the Collaboration has been successful in providing a consistent message to many different populations.

Lessons Learned:
Some of the things we learned almost immediately were to provide refreshments at all presentations, offering incentives drastically increases participation, speakers of the same cultural background as the audience are received much more openly, and it takes an enormous amount of energy and commitment from each Collaboration member to keep the momentum going.

Since November 2000, the Collaboration has grown exponentially. Various agencies have expressed an interest in becoming part of the collaboration and meeting their agency goals and objectives without duplicating services of other organizations. New Collaboration members include Planned Parenthood of Central Texas, McLennan County's Texas Cooperative Extension, and the DePaul Center, which provides mental health services in McLennan County.

Braided Funding...Braided Programs

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Essential MCH Functions:	MCH Initiatives
Prenatal care Prevention of Perinatal HIV Transmission Building coalitions & partnerships	Development of models Promote compatible, integrated services system initiatives Provide outreach services Identify high-risk/hard-to-reach populations & methods to serve them Provide, arrange, administer direct services Identify alternative resources to expand system capacity

Description

Family Connections is the District of Columbia's Ryan White Title IV project providing prevention and intervention services targeting families affected by HIV disease. A model public/private partnership has been established that has resulted in the implementation of a safety-net program for pregnant women at risk for transmitting HIV to their unborn infant. The Ryan White Title IV program housed at Children's National Medical Center (CNMC) funds two case management assistants placed within the DOH Healthy Start Project, Maternal and Family Health Administration, Department of Health (DOH). Family Connections receives a supplemental grant from the DOH HIV/AIDS Administration (HAA) for a social work case manager assigned to the special Healthy Start HIV outreach initiative. The initiative "braids" funding and programs supported by the Title V State agency's Healthy Start Project, the Centers for Disease Control and Prevention, and the Ryan White Title IV provider.

Objectives

1. Maximize resources allocated for reduction of perinatal HIV reduction transmission. By blending the primary outreach to pregnant women 2. programs funded under Healthy Start with the HIV outreach and case management function of Family Connections, the Title IV project.
3. Create a solid platform for increasing the investment in this issue among private sector medical providers.
4. Provide specialized support for pregnant women who either did not know their HIV status or who were infected but not connected to specialty health care.

Barriers Encountered

1. During the first 18 months of implementation, the number of referrals from Healthy Start nurse case managers and outreach staff was lower than expected.
2. In-service training offered to Healthy Start staff failed to adequately address staff issues related to the special outreach team which has its client/worker relationships.
3. The special outreach team was not co-located with the main Healthy Start case management staff, although it was housed in an Administration facility. This appears to have interfered with the formation of trusting professional relationships between the special team and the Healthy Start staff.

Strategies to Overcome

1. Family Connections is adjusting its curriculum for in-service training of referring outreach agencies.
2. The referral base has been broadened to include the recently re-established nurse case management program serving Wards 1-4, which is administratively located within the Community Services Unit of the Administration. This staff is housed in the same office as the special outreach team. The total city wide referral rate has increased.
3. The Family Connections special outreach team will seek to establish Memoranda of Agreements (MOAs) with other perinatal outreach projects to expand the referral base. The MOAs will address in-service training and provide protocols for face-to-face interactions among individual front-line staff on a regular basis.

Funding Source: CDC Prevention Grant, Ryan White Title IV Healthy Start Grant
Budget: $160,000.00

Role of Health Department:

From 1991-1997, the Ryan White project was located within DOH. When it was transferred to Children's National Medical Center (CNMC), it was renamed Family Connections, but it retained collaborative working agreements with DOH, Howard University Hospital, and D.C. General Hospital. A core group of DOH administrators continues to engage in cooperative planning for program implementation with the private sector program leadership. DOH provides funding for the special outreach team in a Title V-supported facility, as well as computer equipment. DOH also provided funding for staff training in program evaluation, and Title IV staff attends all training sessions offered to vendors by the HIV/AIDS Administration.

Accomplishments:

1. Established an HIV specialty team in the DOH Maternal and Family Health Administration.
2. D.C. was selected as one of two states to participate in the Train-the-Trainer program funded by CDC and implemented by the National Pediatric and Family HIV/AIDS Resource Center.
3. Increased the visibility of the issue within wider arenas of DOH and the private providers.
4. D.C. was selected to participate in the in the CityMatCH Perinatal HIV Transmission Learning Cluster and the AMCHP Perinatal HIV Transmission Action Learning Lab.

Lessons Learned:

When "braiding" programs with different funding streams and different, although complementary programs, co-location of staff is a critical variable.

DOH needs a dedicated Public Health Analyst to coordinate the Reduction of Perinatal HIV Transmission Initiative.

How to create a very productive planning team representing Ryan White, CDC Prevention of HIV, Title V Maternal and Child Health block grant, and Healthy Start funding streams.

Folic Acid Man

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Essential MCH Functions:	**MCH Initiatives**
Prenatal care	Implement/support education services for special MCH problems

Description
The Folic Acid Coalition Delaware, working under the direction and leadership of the March of Dimes, wanted to find a unique way to reach people with the folic acid message. A Public Health Nurse representing the Division of Public Health had the vision for "Folic Acid Man." Folic Acid Man was created as a costume that resembles a superhero. The body suit is green to represent green leafy vegetables as a source of folic acid in addition to the orange lettering and shorts, which represent oranges as a source of folic acid. The costume also has a tool belt, which holds health education literature, multivitamins, broccoli and an orange, representing birth defect fighting weapons. It is important that the person representing Folic Acid Man is knowledgeable about the importance of folic acid. Folic Acid Man is available for parades, community parties, health fairs and other public events to spread the word about the importance of folic acid for not only women, but teens, children and men.

Objectives
Folic Acid Man objectives work in conjunction with the coalition objectives to:
1. Increase the proportion of women of childbearing age who are aware of folic acid from 75 percent to 78 percent by December 2001.
2. Increase by 10 percent the amount of news coverage and or publicity generated around folic acid, by December 2001.

Barriers Encountered
Folic Acid Man is a volunteer, although the Division of Public Health pays for some of his time. It is difficult to make time for all the requested events. Finding reliable volunteers available at various hours presents a challenge. The individual who serves as Folic Acid Man needs to be well educated in folic acid nutrition, should be able to relate well to people, and be able to engage people in short interactions that teach a valuable message.

Strategies to Overcome
Another volunteer has been recruited to cover some of the Kent and Sussex County events. This volunteer is a woman, so her role becomes Folic Acid Woman.
It would be good to recruit a number of retired or nonworking individuals who would be willing to volunteer their time to this cause. Volunteers need to be educated in appropriate messages and methods of reaching audiences of different types.
Several versions of the suit should be replicated.

Funding Source: Private Source
Description of other sources: March of Dimes
Budget: $500.00

Role of Health Department:
The Division of Public Health participates in the Folic Acid Coalition. A Public Health Nurse and a Public Health Nutritionist are active members of the Coalition and participated in the planning, implementing and evaluating of this, as well as other Coalition activities. The Public Health Nurse developed this idea.

Accomplishments:
Folic Acid Man is becoming a household name in the maternal child health community of Delaware and hopefully will become a recognized hero among the general community. He is often asked to participate in community events by community members. There have been so many requests that the Folic Acid Coalition has created a Folic Acid Woman to reach more people. Folic Acid Man has been featured in a number of newspaper and magazine articles, in addition to local news broadcasts. Folic Acid Man was recognized in the National March of Dimes Annual Report.

Lessons Learned:
Health education efforts revolving around folic acid do not have to be extravagant. Learning should be a fun and easy activity. A simple message is best. Promoting a clear visual message in addition to verbal interaction is important. Folic Acid Man is one of the many successful Health Education efforts of the Folic Acid Coalition of Delaware which is lead by the local chapter of the March of Dimes and includes other agencies such as Christiana Care Health System, the Perinatal Association of Delaware, A. I. DuPont Hospital for Children, and the University of Delaware, Department of Nutrition and Dietetics, and the Division of Public Health.

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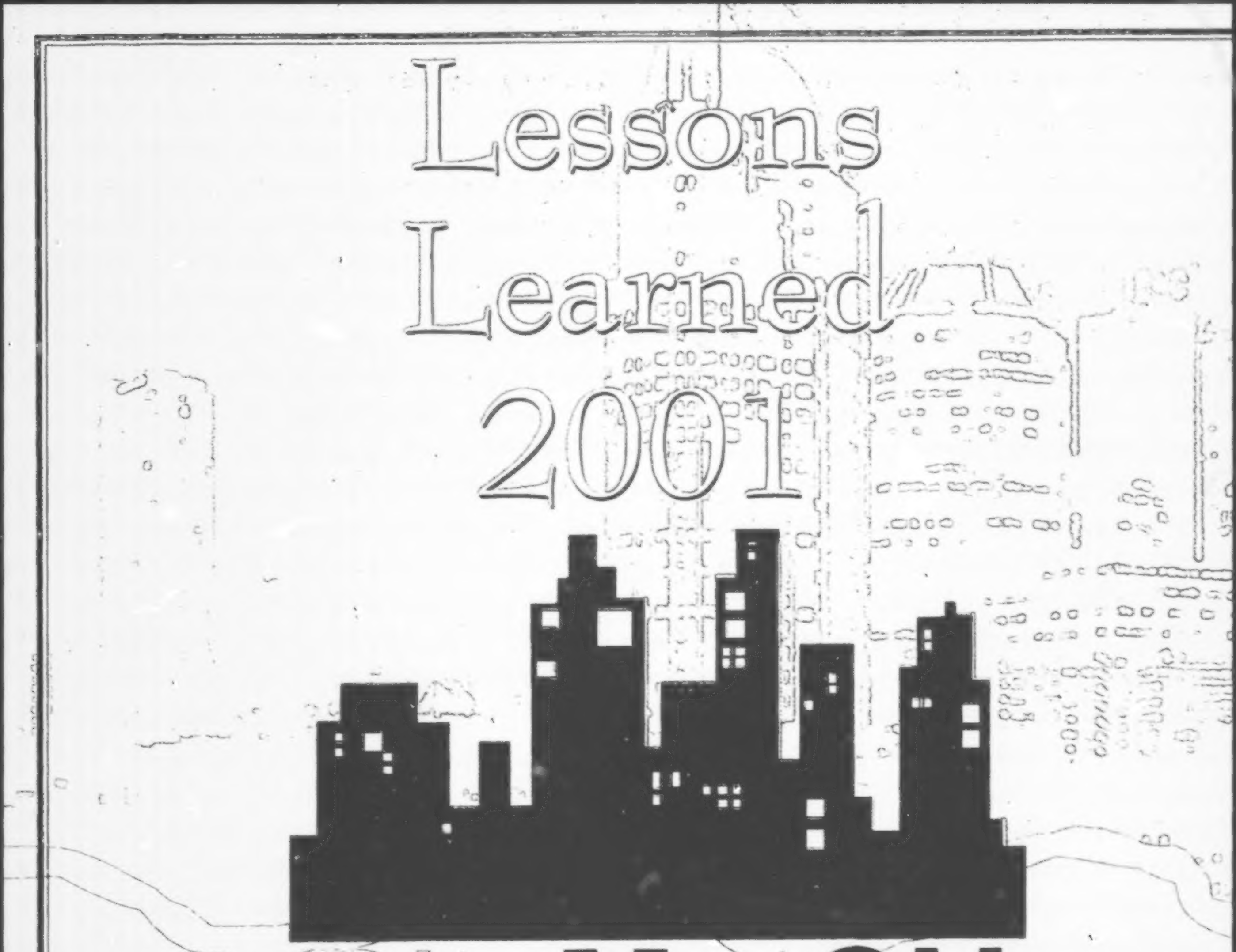

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